DOCUMENT RESUME

ED 477 955 PS 031 367

AUTHOR	Morgan, Linda Jewell
TITLE	Making Children a National Priority: A Framework for Community Action Monograph [with] Executive Summary.
INSTITUTION	Child Welfare League of America, Inc., Washington, DC.
ISBN	ISBN-0-87868-882-2
PUB DATE	2003-00-00
NOTE	108p.
AVAILABLE FROM	Child Welfare League of America, Inc., Publications Ordering Department, P.O. Box 2019, Annapolis Junction, MD 20797-0118 ($9.95). Tel: 800-407-6273 (Toll Free); Fax: 202-638-4004; e-mail: cwla@pmds.com; Web site: http://www.cwla.org.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS
DESCRIPTORS	*Adolescents; Agencies; Change Strategies; *Child Advocacy; *Childhood Needs; *Children; *Community Action; Community Programs; Models; Program Effectiveness; Public Policy; *Well Being
IDENTIFIERS	Advocacy Planning; Child Welfare League of America; Conceptual Frameworks; Indicators

ABSTRACT

This monograph presents a comprehensive, community-based framework to support individuals, agencies, and communities in efforts to improve the well-being of children and youth. The monograph, with accompanying executive summary, features five childhood needs and describes promising strategies for meeting those needs. Chapter 1 of the monograph presents a vision for America in which all children are healthy and safe and develop to their potential with the support of a nurturing family and strong community. Chapter 2 identifies six key components of the framework: (1) a national vision for children; (2) approaches to meeting children's universal needs; (3) fundamental principles that can guide efforts to meet children's needs; (4) ways that a broad range of people can be involved in meeting children's needs; (5) what is known about effective practices and programs and how this knowledge can be applied to meeting children's needs; and (6) key indicators for measuring progress. Chapters 3 through 7 each address one of the five universal needs of children: (1) "the basics," namely nutrition, economic security, adequate shelter and clothing, education, and primary and preventive physical and mental health care; (2) good relationships with family/caregivers, community members, and peers; (3) opportunities that motivate and equip children to succeed; (4) safety; and (5) healing when children have suffered harm. Each chapter summarizes relevant practical wisdom and research regarding the need's importance, presents statistics indicating how well the nation is meeting this need, describes some effective strategies to increase protective factors and avert/minimize threats to healthy development, and briefly describes model practices related to the need. Chapter 8 addresses community partnerships, social inclusion, the need to reshape professional roles, and concludes with a call to action. (Contains 404 endnotes.) (KB)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 477 955

MONOGRAPH

MAKING CHILDREN A NATIONAL PRIORITY

A Framework for Community Action

CHILD WELFARE LEAGUE OF AMERICA

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

This document has been reproduced as received from the person or organization originating it.

Minor changes have been made to improve reproduction quality.

Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

Susan J. Brite

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

2B

ED 031367

BEST COPY AVAILABLE

MONOGRAPH

MAKING CHILDREN A NATIONAL PRIORITY

A Framework for Community Action

CHILD WELFARE LEAGUE OF AMERICA

by
Linda Jewell Morgan,
Linda S. Spears,
and Caren Kaplan

WASHINGTON, DC

The Child Welfare League of America is the nation's oldest and largest membership-based child welfare organization. We are committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.

© 2005 by the Child Welfare League of America, Inc. All rights reserved. Neither this book nor any part may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, microfilming, and recording, or by any information storage and retrieval system, without permission in writing from the publisher. For information on this or other CWLA publications, contact the CWLA Publications Department at the address below.

CHILD WELFARE LEAGUE OF AMERICA, INC.
HEADQUARTERS
440 First Street, NW, Third Floor, Washington, DC 20001-2085
E-mail: books@cwla.org

CURRENT PRINTING (last digit)
10 9 8 7 6 5 4 3 2 1

Cover and text design by Jennifer R. Geanakos

Printed in the United States of America

ISBN # 0-87868-882-2

Contents

Acknowledgments v

1. Imagine an America... 1

2. Key Components of the Framework 5

3. "The Basics" 11

4. Relationships 25

5. Opportunities 31

6. Safety 39

7. Healing 57

8. Making Children a Community Priority 67

Endnotes 71

Acknowledgments

We are indebted to the many people who helped with the development of this Framework. Many thanks to the Framework Strategy Team, a group of Child Welfare League of America (CWLA) staff, who lent their time, creativity, and broad expertise to the endeavor. They provided honest feedback and wise counsel over the past three years. We thank the numerous CWLA staff and CWLA members who contributed ideas and resources to the Framework and acted as reviewers at various stages along the way.

Our special thanks go to Ruth White, CWLA Director for Housing and Homelessness, for lending her enthusiasm, fresh ideas, and capable hand to this effort; to Dr. Margo Coleman, CWLA Assistant Director of Research, who brought deep passion, significant rigor, and dedication to the conceptualization of and research for the project; and to Laura Stewart, CWLA Program Manager for Housing and Homelessness, who generously and tirelessly researched many of the topics contained in the monograph.

Thanks to Shay Bilchik, CWLA President/CEO, and Bob McKeagney, CWLA Vice President for Program Operations, for their direction, support, and commitment to a comprehensive focus on child well-being.

Our gratitude is due Karabelle Pizzigati, Teri Martin, and Sarah Ingersoll, our talented consultants, who drafted and edited sections of this work. They helped us "think outside the program box" and approach our work from the vantage of children's needs and communities' assets. Our thanks also to Eve Malakoff-Klein, Julie Gwin, and Jennifer R. Geanakos for their work on the editing and design of the Framework components.

Finally, many thanks to the Edna McConnell Clark Foundation for providing the inital funding for this effort and to Susan Notkin, Director, and the staff of the foundation's Center for Community Partnerships in Child Welfare, at the Center for the Study of Social Policy, for their continuing support.

–Linda Jewell Morgan, Linda S. Spears, and Caren Kaplan

Imagine an America...

Imagine an America where *every* child is healthy and safe and where *all* children develop to their potential. Imagine that all children are nurtured, each getting what they need, as they require. Imagine that every child grows into an adult who is able to make positive contributions to family, community, and the nation.

Americans have the spirit, creativity, and perseverance necessary to make dreams come true for our children. Every day in homes, neighborhoods, and classrooms across this nation, parents, caregivers, relatives, neighbors, and teachers act to ensure the safety and healthy development of millions of children. Parents show extraordinary inventiveness in juggling many responsibilities to be where their children need them. Grandparents and other relatives have long stepped up to take care of children when parents cannot. Teachers often see and fan the sparks of learning that others may not witness, and serve as important mentors and advisers beyond the classroom. Many routinely use their own resources to support educational activities for their students. In communities across the country, neighbors come together to help each other and to watch out for and protect the children in their communities.

In the past decade, the combined efforts of families, communities, lawmakers, researchers, teachers, law enforcement, medical professionals, social workers, and many others have markedly improved the well-being of children. More children are benefiting from early childhood education and more youth are graduating from high school than ever before. Infant mortality has dropped significantly for all racial and ethnic groups, though substantial racial and ethnic disparities remain. Fewer adolescents are dying of gunshot wounds. Youth are committing fewer homicides.

Throughout our nation's history, strengthened public policies, advances in research, and effective services have made remarkable and lasting improvements in the lives of children. We have nearly eliminated polio, measles, mumps, and other diseases that used to kill and maim thousands upon thousands of children.

Most children, youth, and families are doing well, but our hope that all children will enjoy good health and well-being, although imaginable today, remains a dream. In 2000, one in six children lived in poverty and an estimated 1.35 million children were homeless at some time during the year. Every day in America, three children die as a result of neglect or abuse, most at the hands of their parents or others entrusted with their care. All of our children are placed at risk by substance abuse and by violence on our streets, in schools, in homes, and in our culture.

Policies, services, and resources to address these problems vary widely across the country and often fall short. Community efforts in behalf of children are often fragmented, uncoordinated, and unsustainable. Too many children and youth, particularly children of color and recent immigrants, remain in harm's way. The promises of equal opportunity and social justice remain unfulfilled for many poor children, youth, and families in the United States. In the world community, despite our great wealth and prowess, we continue to compare poorly with other industrialized nations on leading indicators of child health and well-being.

NOW IS THE TIME...

There is so much more that we can do to support the healthy development of our nation's children, youth, and families. We stand at the threshold of a new era full of promise for ensuring the health and safety of all of America's children. Solutions abound! Every day our knowledge of what works to ensure the optimal development of children increases, as our colleges and universities expand cross-discipline study and research. Rapidly emerging knowledge on the development of the brain tells us that what happens before birth and in the early years matters a great deal, but that isn't the end of the story. In adolescence, the brain again undergoes remarkable transformations. In fact, human beings continue to grow and learn, shaped by trauma and positive experiences, throughout their lives.

Research and practice have broadened their focus from managing crises, "fixing" problems, and reducing harm, to promoting healthy development and child well-being. Human services professionals support families not only through intervening when they are in crisis, but also by strengthening their abilities to prevent problems from happening. From academia to field evaluation, researchers are exploring ways that families, communities, and professionals can identify children at risk and collaborate to increase their resilience and protect them from harm.

We continue to enhance our understanding of the complex of factors that interact to shape the development of children and youth. It has become increasingly clear that helping children grow into healthy and resilient adults requires a comprehensive, collaborative, and coordinated approach implemented through partnerships of citizens, professionals, and policymakers. Diverse communities are experimenting and finding success with a variety of collaborations among citizens and across systems. For example, many tribal governments are strengthening their child welfare and prevention programs, and successfully rebuilding healthy communities based on traditional values.

The terrorist attacks of September 11, 2001, served as stark reminders of our interdependence and renewed our concern and care for one another. As Americans have learned to live with greater fear and uncertainty, we have also strengthened our resolve to help our children find safety and security. We can act on that resolve by learning better ways of caring for our children, pooling our resources, and coordinating our efforts. To make substantial gains, however, we will most certainly need to invest more in caring for our children.

Against the backdrop of our shaken economy, some may say that America cannot afford to invest more money in its children. The human and economic costs of ignoring children's needs, however, are much greater than the costs of preventing problems or effectively intervening when they do occur. Every year, governments and the private sector spend billions of dollars to cope with the multiple negative impacts of inadequate prenatal care, child abuse and neglect, teen pregnancy, failure to complete high school, and juvenile crime, all of which can be avoided by investing in the healthy development of children. By investing our resources more wisely, and focusing on collaborative strategies for preventing and remediating problems, we can conserve resources and minimize the pain and suffering experienced by children and families.

We know about the American "can do" attitude. We also know that Americans are willing to invest more in children and their futures. Polls have repeatedly indicated that the public is willing to pay more in taxes for effective services and programs. Findings from a 1999 survey regarding child abuse,[1] for example, indicated that Americans think that it is a serious problem, that everyone shares responsibility for solving the problem, and that they would be willing to pay increased taxes to address it.

Significantly improving the health, safety, and development of all of America's children will take the talents, hard work, and long-term commitment of millions of people from many walks of life. Across the country, communities and their elected leaders must expand and intensify their efforts to provide avenues for children and youth to succeed. Giving all children the opportunity to grow up healthy and strong will require flexibility, tenacity, teamwork, and willingness to invest sufficient resources to get the job done.

THE ROLE OF CWLA

Now is the time for us to take on these challenges, and the Child Welfare League of America (CWLA) stands ready to assist communities to do so. CWLA was established in 1920 to guard children's rights and serve children's needs. With its current roster of more than 1,100 public and private nonprofit agencies, CWLA stands in the service of children, youth, and families. CWLA envisions a future in which families, neighborhoods, communities, organizations, and governments ensure that all children are provided with the resources they need to grow into contributing members of society. "Making children a national priority" is the major theme of CWLA's strategic plan for 2000 to 2010.

CWLA is the nationally recognized standard setter for child welfare services. Its government affairs staff advocates for and monitors the development and implementation of federal and state legislation. Through its programs, publications, research, conferences, professional development, and consultation efforts, CWLA teams with professionals, agencies, parents, and communities in their efforts to improve the lives of children. In one effort, CWLA and The Prudential Foundation teamed up to create Prudential Positive Parenting, helping thousands of child day care programs respond to parents' needs for information and advice on positive parenting. CWLA speaks with authority and candor about the status and needs of American children, youth and their families, providing a strong voice for what is learned from its members, and the families, children, and communities they serve.

The last two years have been a time of accelerated learning and growth for CWLA as it has expanded its focus beyond child abuse and neglect to child well-being, reflecting a renewed commitment to holistic, evidence-based approaches. New and reorganized divisions that focus on juvenile justice, behavioral health, and child, youth, and family development enhance CWLA's capacity to provide assistance and support to agencies, families, and communities. CWLA's Research to Practice (R2P) Initiative works to better unite the worlds of practice and research.

CWLA continues to strengthen its relationships with many nonprofit, corporate, and public organizations concerned about children. Our work in behalf of children is enriched as well by collaboration across disciplines and with diverse partners in the service and consumer communities. Respectful attention to the needs and preferences of diverse families and communities is essential to enhancing the well-being of all children.

DEEPENING THE COMMITMENT

With the Framework for Community Action advanced in this monograph, CWLA reaffirms and deepens its commitment to support families, communities, agencies, and policymakers in their efforts to improve the lives of America's children. The Framework offers a broad and inclusive vision of what America's children need to be healthy and safe, and to thrive, and what it will take for all families and communities to meet those needs. Drawing on knowledge

from basic and applied research, the work of social service practitioners, and the experiences of families and children, the Framework articulates

- a clear vision for children that is national in scope,
- approaches to meeting children's five universal needs so they can grow up safe and healthy,
- fundamental principles that can guide efforts to meet children's needs,
- ways that a broad range of people can be involved in meeting children's needs,
- what we know about effective practices and programs and how we can apply that knowledge to meet children's needs, and
- key indicators we can use to measure progress in meeting children's needs.

A wealth of excellent models and resources already exists to guide our work. By melding these into a broad blueprint for change, CWLA's Framework brings into sharper focus the scope of the challenges and opportunities that communities will encounter in working to better meet the needs of their children, youth, and families.

This monograph describes the key components of the Framework and how they fit together. By laying out a blueprint and offering tools and resources communities can use to support families and children, CWLA hopes to help ensure that all children in America have the opportunity to reach their full potential. CWLA remains committed to serving as a strong voice for America's children and will direct its energy and resources to work in partnership with parents, communities, and professionals to ensure a bright future for every child.

Key Components of the Framework

This chapter describes the Framework's vision for all children, the principles that guide it, and the various kinds of people whose commitment and teamwork are crucial to its success. It notes CWLA's role in supporting the efforts of families and communities and partnering with other national efforts. The chapter concludes with a discussion of the sources of practices and programs required to meet children's universal needs, and of the importance of measuring their effects on child well-being.

THE VISION: SAFE, HEALTHY, AND THRIVING CHILDREN

The Framework envisions an America where every child is healthy and safe, and develops to his or her fullest potential with the support of a nurturing family and strong community. This ambitious vision is grounded in respect for the diverse communities where children and families live and echoes the goals of many national, state, and community-based initiatives currently being pursued in behalf of children. Transforming this vision into reality requires embracing it with the commitment to achieve measurable, positive outcomes that reflect the needs of children and families in their home communities.

FIVE UNIVERSAL NEEDS OF CHILDREN

Children have five universal needs that must be met to ensure their survival and promote their healthy development. All children in all communities require:

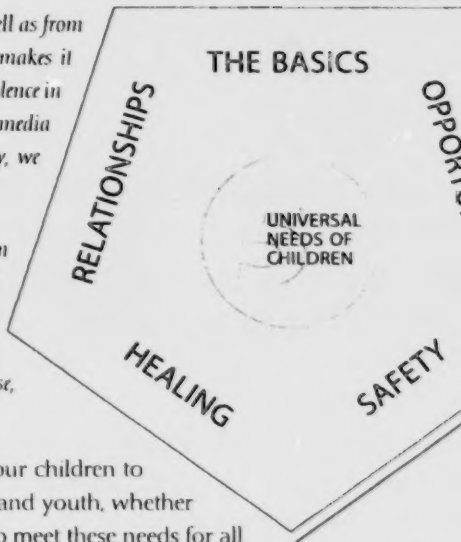
***"The Basics"**: At the most fundamental level, children require proper nutrition, economic security, adequate shelter and clothing, education, and primary and preventive health and mental health care.*

***Relationships**: Close, nurturing relationships with parents, kin, and other caregivers allow and encourage children and young people to grow and thrive. Caring relationships with community members, including neighbors, coaches, teachers, and faith community leaders and members, strengthen social and relationship skills, improve self-mastery, and enhance self-esteem. Good relationships among children and youth themselves reinforce healthy behaviors and increase positive learning opportunities.*

***Opportunities**: Providing a childhood full of experiences and opportunities that motivate and equip children to succeed is the collective responsibility of individuals, families, neighborhoods, and communities. Children and youth need opportunities to develop their talents and skills, to contribute to their families and communities, and to make positive connections to their cultures, traditions, and spiritual resources. Children with early indications of physical, cognitive, or emotional disabilities must be provided with early assessment and intervention, to prevent later, more serious problems that can unnecessarily limit their long-range potential.*

Safety: *Keeping children safe from abuse and neglect by their caregivers, as well as from witnessing or being victimized by family, school, or community violence, makes it much less likely that they will become either victims or perpetrators of such violence in the future. By also protecting children from the harms of discrimination, media violence, internet victimization, environmental toxins, and accidental injury, we increase their likelihood for success.*

Healing: *When we are unable to protect children, we must do all that we can to ease the impact of the harm they have suffered. Helping children and youth to heal involves ensuring their immediate and ongoing safety, supplying immediate and continuing emotional support, assessing the need for and providing medical, mental health, and other needed services, and, in some case, making amends through restorative justice practices.*



These five needs are closely interrelated and must be met for our children to be safe, healthy, and thriving. Each need is common to all children and youth, whether they live at home, in a juvenile detention facility, or on the streets. To meet these needs for all children in a community requires that many people participate in multifaceted, comprehensive approaches that are guided by a common set of principles.

GUIDING PRINCIPLES

Nine core principles guide the vision and the framework for action.

Supporting families: *Children grow best in families. By supporting families in nurturing their children, professionals and community members can help to ensure that parents, other relatives, and caregivers have the skills and resources to raise healthy and well-adapted children.*

Promoting prevention: *Providing help to children and families to prevent problems before they occur is a sound social and fiscal policy. Programs and practices that nurture and protect children in their earliest development, that prevent abuse and neglect, and that detect and intervene at the earliest possible indication of risk should be available to all families.*

Advancing social justice: *All children, regardless of gender, ability, economic status, and ethnic, racial, spiritual, and cultural background, have an equal right to have their universal needs met. All community partners can advocate for the ideals and values of social justice both locally and globally.*

Working collaboratively: *When people come together collective capacities emerge that individual partners do not possess. Communities can harness this synergy to solve shared problems and work toward the common good.*

Respecting and valuing diversity: *Diverse cultures, traditions, and perspectives are sources of strength and creativity that community partners can draw upon to nurture healthy families and children.*

Building capacity: *By recognizing and nurturing the assets and strengths of children, youth, families, and communities, we tap into sources of energy and creativity that have the greatest potential for meeting children's needs and encouraging their optimal growth. Consciously developing individual, group, and community capacity strengthens everyone.*

***Nurturing leadership**: Leadership requires dedication, passion, and a willingness to take risks. It cannot be conferred simply by election or appointment to a position of authority, but rather comes from those willing and able to inspire and guide others to get things done in behalf of families and children.*

***Using evidence-based strategies**: Applying knowledge of factors and strategies that contribute to or impede healthy human development can help community partners to design and implement policies, practices, and programs that are effective in helping children to thrive.*

***Measuring results**: Using clear outcome measures to guide and evaluate our efforts increases the likelihood that our work will result in positive results for children, youth, and families.*

PEOPLE AND PARTNERSHIPS

People are at the heart of a community's ability to ensure safety and well-being for all children. Americans have a long history of building on the talents of individuals to create new and better ways to work together to accomplish everything from harnessing electricity to bringing digital technology into our homes.

Working individually and collectively, the five groups of people delineated below can ensure futures filled with positive potential for all children.

***Parents, caregivers, and families**: Healthy families and supportive parents are crucial to children's well-being, shaping their values and behaviors in enduring ways. Communities must encourage and support caregivers in meeting the needs of their children and youth. Communities also benefit from parents' participation in and leadership of community initiatives dedicated to raising healthy, thriving children.*

***Children and youth**: Recognizing that children are resilient, with many assets and strengths, community partners can work with them to nurture their talents and to provide them with opportunities to serve and transform their communities.*

***Neighbors and members of communities**: All adults must share the responsibility for nurturing and supporting children and families in their communities. As coaches, mentors, neighbors, employers, and members of faith communities, people can help to ensure children's healthy development and safety. By working together as members and leaders of community-based collaboratives, community residents can support comprehensive strategies that will strengthen families and help all children to reach their full potentials.*

***People working in service agencies, institutions, or systems**: Professionals, natural helpers, and volunteers who work for public service agencies have specialized skills and talents essential to the success of community partnerships' work in behalf of children and youth. They can also act as conveners, catalysts, and facilitators for a wide range of community change efforts.*

***People who influence laws, traditions, culture, and society**: Elected officials and other policymakers, business executives, and spiritual, social, and scientific leaders all exert considerable influence on how our communities shape and support the growth of children and youth. These individuals can ensure the safety and well-being of children by supporting community-based initiatives that encourage local creativity and accountability.*

PRACTICES AND PROGRAMS THAT MEET CHILDREN'S NEEDS

Communities need a comprehensive system of services and supports to ensure that parents are able to meet their children's needs, and to provide children and youth in crisis with the help they need. To this end, the Framework describes model practices and programs, ranging from tried and true parenting approaches to formal programs for children needing intensive treatment. These services and practices will unfold in communities; each community, in turn, will tailor and fine-tune its efforts to meet its respective needs.

Building on Common Sense and Experience

For generations, common sense and experience have guided elders as they instruct their sons and daughters in the care of a first grandchild. This wisdom can help us not only in meeting daily needs, but also in prioritizing our responses to community concerns and developing action strategies.

Looking to Data, Information, and Research

Common sense and experience are invaluable, but they often are not sufficient to solve many of our problems. We must rely on information and research that helps us to more accurately understand the challenges facing children and families, to choose and evaluate solutions, and to broaden our understanding of community dynamics. To move from formulating good ideas that seem likely to work to implementing practices and programs that effectively support children and families, we must augment the common sense of practitioners with objective knowledge gained through broad-scale research and targeted program evaluations.

Public policy at all levels increasingly calls for a variety of assessments. The 1993 Government Performance and Results Act provided broad federal impetus to measure results. In the child welfare arena, the 1997 Adoption and Safe Families Act revamped the assessment of children and families involved in the foster care system. In communities, new and continuing programs now routinely must pay attention to evaluation, outcomes, and performance.

Highlighting Effective Practices and Programs

We already know a great deal about what works. The Framework highlights existing and emerging knowledge about effective programs and practices. Throughout this monograph examples of ideas that work for families and caregivers are provided. These include informal neighborhood- or community-based approaches, as well as professional agency and institutional activities. These examples are by no means comprehensive. Many communities already have some of these promising and proven strategies in place, but all recognize the imperative to improve and enhance their capacity to protect and nurture children. Through its Research to Practice (R2P) initiative, CWLA will continue to explore, analyze, and disseminate information on effective practices and programs that will help communities to fill the unmet needs of children, youth, and families.

MEASURING PROGRESS

Benchmarking our efforts is essential. At the national level, CWLA intends to establish a set of core national benchmarks grounded in solid research. This will enable us all to capture our collective progress employing a common language and measures, and to use this knowledge to

promote specific actions that will improve results. The Framework's *Community Implementation Guide* includes suggested indicators for each of the five universal needs of children that may prove useful to communities as they develop their own measures.

PARTNERSHIPS AT THE NATIONAL LEVEL

A number of national organizations, government agencies, and local communities have embraced community change strategies designed to improve the lives of children and families. Each plays an important part in helping to stimulate community action in behalf of children.

A few key national initiatives serve as markers because, like this Framework, they embrace a broad vision for the future of our children. These include:

- *America's Promise–The Alliance for Youth* is dedicated to mobilizing the nation's groups and organizations to strengthen the character and competence of America's youth. Its goal is to connect young people, from birth to age 20, with support that keeps basic promises to children.
- *The National Call to Action*, sponsored by San Diego Children's Hospital, is a collaborative initiative of national organizations addressing child abuse and neglect through social action, policy, and program efforts. It links the work of its partner organizations rather than replicating their efforts.
- *"Leave No Child Behind"* has long been a guiding theme for the work of the Children's Defense Fund. Its current focus is an aggressive and comprehensive national policy agenda for children that complements the Framework's focus on community level strategies.
- *The UN Convention on the Rights of the Child*, while international in its scope, expansive in its strategies, and still not ratified by the United States, expresses important values and concepts concerning the well-being of children. It offers a sound foundation upon which strategies for action can be built.

Other initiatives to improve the well-being of the nation's children and families involve joint efforts of several federal agencies, tribal governments, associations of states and of elected officials, foundations, and professional organizations. Where we can join forces, build strategic alliances, and enhance our capacity to attain shared goals, we can and will increase the strength of our voice in behalf of children. Strategic partnerships between CWLA and other national organizations will provide expertise in content areas that complement CWLA's efforts. These organizations will also continue to advocate for national policies and resources that support community-based work.

MOVING TO ACTION

Through its members, CWLA is poised to introduce the Framework nationwide to hundreds of local communities. With support from others, CWLA will offer both broad support and hands-on assistance to communities to customize strategies to build upon what they already have in place.

THE MONOGRAPH

The next five chapters of the monograph each address one of the five universal needs of children. Each chapter begins with a vignette that illustrates how an individual, group, or

community successfully met this need for children or youth. Following the vignette, the chapter is divided into several segments that describe a facet of the universal need. For example, "The Basics" chapter includes segments on such topics as nutrition, housing, and education. Each segment

- begins with a definition of the need and a summary of relevant practical wisdom and research regarding why it is important to meet this need;
- presents selected national statistics that indicate how well we are doing as a nation in meeting this need for children;
- describes some solutions to meeting the need, including effective strategies to increase protective factors and to avert or minimize threats to healthy development; and
- briefly describes one or more model practices, not as a comprehensive catalogue of "what works," but rather as an assortment of practices and programs that show promise.

Researchers and others have identified, and will continue to discover, a wealth of information regarding proven and promising approaches. CWLA will contribute to this body of knowledge through its Research to Practice (R2P) initiative.

The final monograph chapter discusses what it will take to make children a community priority. It addresses partnerships, social inclusion, and the need to reshape professional roles. The monograph ends with a call to action.

"The Basics"

our young men clad in
orn jeans, sweat-soaked
ee-shirts, heavy leather
ce-up work boots, and
early new tool belts squat,
an forward, and staple
ough, black shingles onto a
lywood roof. They built this
ouse from scratch as part
f a program offered by the
areer and technology
ducation department at
arkside High School in
alisbury, Maryland.

The school needed a
uyer for its senior class
roject... Salisbury Neigh-
orhood Housing Services
SHNS) needed housing
tock... and there is a family
hat needs a new home.

"We bring the real world
f construction to young-
ters, so they have access to
. We at SHNS think this is
n excellent example of
ultilevel partnering within
he local community."

—Neighborworks

Children and youth have many needs that must be met for survival and for development to occur along a healthy trajectory. At the most basic level, these include economic security and stability, proper nutrition, adequate housing, a healthy start, primary and preventive health and mental health care, and education. Communities can help to meet the basic needs of children, youth, and their families through innovative community partnerships, like the one noted above.

EQUALITY

We cannot meet the challenge of fulfilling the basic needs of this country's children without first considering the issue of equality. Millions of poor and minority children in America face harsh inequalities. These range from prenatal exposure to environmental toxins to lack of nutritious food, inadequate health care, and substandard education. Throughout the discussion of the five universal needs of children, we cite numerous examples of inequalities experienced by the poor and by children and families of color.

Children of color are more likely to be poor. They face inequalities because of poverty, language barriers, culturally inappropriate services, and personal or institutional racism. Recent federal legislation also placed severe restrictions on eligibility for TANF, Food Stamps, Medicaid, and other types of assistance for poor immigrant children and their families.[3]

Numerous approaches to addressing inequality exist.[4] Many of the strategies and model practices aimed at meeting children's needs described in the Framework advance a social justice agenda. The key first step is open dialogue about the causes and effects of inequality. No community can provide all of its children with the highest quality of life without addressing the issue of unequal treatment. By developing and implementing strategies to meet children's universal needs outlined in this Framework, communities can move toward greater equity for all children.

ECONOMIC SECURITY AND STABILITY

The Need

Parents and other caregivers require economic resources to provide their children with proper nutrition, adequate housing, and sufficient health care. Although economic resources provide no guarantee of a child's healthy development or well-being, poverty is correlated with a wide range of negative child outcomes.[5] Poor children are likely to experience more risks and have fewer protective factors and resources than nonpoor children.[6]

Many poor children begin their lives at a disadvantage because of inadequate prenatal care, poor maternal nutrition, or birth complications. They often also face a wide array of familial and other environmental risks, including low levels of parental education, increased

BEST COPY AVAILABLE

levels of familial stress, poor social support, and limited community assistance. Compared with other children, poor children are more likely to have school problems, become teen parents, and, as adults, to earn less and to be unemployed more frequently.[7]

Poverty during early childhood may be more damaging than poverty experienced later in life because much of the foundation for learning is built in the early years. Poor children score lower on measures of vocabulary, language skills, understanding of number concepts, organization, and self-regulation.

The Challenge

The booming economy in the 1990s resulted in increases in overall income levels, and modest declines in poverty levels relative to economic gains. The percentage of U.S. children living in families with high incomes grew to 29.7% in 2000, while one in three children (34%) lived in families with medium incomes.[8]

Poverty[9] remains prevalent and debilitating, however, for millions of U.S. children, youth, and families. Nearly one of every six children living in America in 2000 (11.3 million children) lived in poverty. Furthermore, "the growing gap between rich and poor children suggests that poor children may experience more relative deprivation even if the percentage of poor children is declining."[10]

Children are almost twice as likely to live in poverty as Americans in any other age group.[11] Although children account for only 26% of the total population, they represent 37% of the nation's poor; for black and Hispanic children, the poverty rate is dramatically higher.[12]

In 2000, more than one in three (35%) children living in poverty had at least one parent working full-time year-round.[13] The real earnings of lower wage labor, however, have declined.

> *The extent of inequality in the distribution of earned income since the 1970s has dramatically increased. While workers with higher schooling levels and more experience have enjoyed increases in their inflation-adjusted earnings, the real earnings of younger and less-educated workers have fallen sharply.*[14]

Although secure parental employment may provide access to health care and reduction of some stresses, poor working parents often face multiple pressures that negatively impact their ability to adequately care for their children.[15]

> *When they are exhausted from low paying jobs and enervated by the sheer demands of coping with inadequate resources, parents simply find it harder to be consistent in discipline, to be responsive to children's needs, and to provide a range of socially and educationally stimulating experiences.*[16]

With the recent economic downturn, the United States may again experience sharp increases in child poverty similar to those that accompanied the recessions of the early 1980s and early 1990s.[17]

Promising Solutions

Raising the incomes of low-income families can positively affect child development, especially for younger children. Although poverty is a serious challenge for parents, however, it does not necessarily determine negative child outcomes. Positive parent-child relations in preschool and elementary school and use of age-appropriate and consistent discipline can help thwart the impact of poverty on children.

Federal strategies that seek to increase low family incomes include income supports (especially the Workforce Investment Act and Temporary Assistance to Needy Families), tax credits

(the Earned Income Tax Credit), federal standards for a minimum hourly wage, child support enforcement, and efforts to help families save money through Individual Development Accounts.

Job Training and Education

Job training–from short-term case management and job search assistance to intensive vocational and technical training to education programs (usually General Equivalency Diploma attainment)–can increase the employment, work hours, and earnings of parents. Although the Personal Responsibility and Work Opportunity Act (PRWORA) in 1996 and the Workforce Investment Act in 1998 successfully moved parents from public assistance to employment, the jobs they provide are often unstable, low skilled, and low paying.

Longer term investments in job skills and education, although more costly at the outset, ultimately appear to have a greater impact on lifting parents out of poverty and a cost-benefit "as families earn more, pay more in taxes, and are better able to support their child's development."[18] Thus, a greater emphasis on education and training in PRWORA would strengthen its outcomes.

Although many parents have temporarily bettered their economic lot through PRWORA, many still struggle to make ends meet and care for their children. Analysis of welfare to work arrangements show that mothers who returned to work from welfare were significantly more likely than other mothers to lack benefits such as health insurance and flexible work and leave policies that allow them to succeed at work while caring for their children.[19] Welfare programs that do not just provide employment, but truly increase family income through employment and earnings supplements have shown positive effects on children, especially their school achievement.[20]

Tax credits, recovery of income from noncustodial parents, and Individual Development Accounts appear to have had an appreciable positive impact on lifting families out of poverty.

Tax Credits

Because maximum benefits are paid to working families below, but near, the poverty level, the Earned Income Tax Credit (EITC) has successfully reduced the number of families living in poverty, lessened the income gap between the richest and poorest families, and increased the labor force participation of single mothers. In 1999, 16 million taxpayers received EITCs totaling $31 billion, with half of these payments going to families with incomes below the federal poverty level. In nine states, these credits were further supplemented by state EITCs.

Research on the federal EITC shows that it lifts more children out of poverty than any other government program. In 1999, 4.7 million people–including 2.6 million children–left poverty as a result of the EITC. An additional 1.1 million children could have been affected if such credits were adopted by all states.[21]

Child Support Enforcement and Individual Development Accounts (IDAs)

During FY2000, as a result of the Child Support Enforcement program, $17.9 billion in child support *payments* were redirected in support of 19.4 million children.[22] Similarly, across a sample of communities, working poor families were able to save an average of $353, which was then matched with federal dollars through IDAs, to grow, on average, to $900 per years.[23]

City-, County-, and State-Level Programs

Numerous programs at the community, city, county, and state levels have reduced child poverty and ameliorated its negative effects.[24] Many states have their own minimum wage standards, some of which exceed the federal minimum wage. Through business development, tax

credits, and incentives, the development of small businesses, business consortiums, job shadowing, mentoring and other approaches, local and statewide economic and community development projects have demonstrated results.

MODEL PRACTICE

The Arizona Opportunities Industrial Center (Phoenix OIC) was founded in April 1967 as a private, nonprofit community-based organization designed to address the critical employability needs of Phoenix's economically disadvantaged and ethnic minority citizens. The Phoenix OIC is an affiliate of the OICs of America and works collaboratively with other community-based organizations to ensure the social and economic viability of disadvantaged individuals in the Phoenix area. Since 1967, the Phoenix OIC has served more than 30,000 people and placed more than 18,300 in meaningful jobs. Statistics show that approximately 45% of the trainees were welfare recipients prior to their enrollment, and the average salary earned at placement after Phoenix OIC training is about 50% higher than at the time of enrollment.

See One America, The President's Initiative on Race (1998): http://clinton3.nara.gov/Initiatives/OneAmerica/Practices/pp_19980729.6693.html.

PROPER NUTRITION

The Need

Children and adolescents need a nutritious diet to aid normal growth and learning. Especially in the early years, adequate nutrition is important for optimal brain development and functioning.[25] Studies have repeatedly shown that maternal malnutrition compromises healthy birth outcomes, affecting the infant's birth weight and important aspects of fetal development. "The earlier the malnutrition occurs, the greater the reduction in brain size, and the longer the malnutrition continues, the greater the effect on the brain."[26]

Poor childhood nutrition lowers children's resistance to disease and increases the risk of future chronic disease.[27] Hunger and malnutrition impede learning and school readiness. As teachers and researchers have pointed out, hungry children cannot concentrate or learn well. They may be irritable and contribute to disruptions in school.

Being overweight during childhood and adolescence can lead to significant weight problems and related health concerns, such as diabetes and heart disease. The problems disproportionately affect low-income groups, and have been linked to subsequent morbidity and mortality in adulthood.[28]

The Challenge

Hunger and Food Insecurity

Hunger is widespread in America. More than half a million children lived in households with child hunger in 2000. In the same year, nearly one of every 25 children in America (4.1%) and one of every nine poor children (11.9%) lived in households where adults were having difficulty securing food, and where at least one adult, and sometimes children, experienced moderate or severe hunger.[29] In households whose members experience hunger, it is believed that adults often go without food, if necessary, so that their children will have food.[30] Thus, children's hunger becomes prevalent only at more severe levels of adult hunger.[31]

Food security is defined as "access at all times to enough nourishment for an active, healthy life."[32] A "food-secure" child or adult can access a sufficient supply of nutritious and safe food without relying on emergency feeding programs, or on desperate measures such as scavenging or stealing.[33] Food-insecure families often experience poor nutrition, anxiety about having enough to eat, difficulty obtaining adequate food, and reliance on emergency food sources. They frequently have to make difficult choices between buying food and paying for other necessities, such as housing and medication. In 2000, 13.9% of all children and 35.3% of poor children lived in households classified as "food insecure without hunger."[34]

Poor Nutrition

Even when nutritious food is readily available, children and adolescents sometimes are provided with or choose to eat a diet that is lacking in sufficient nutrients. They establish poor eating patterns that often continue into adulthood. In 1998, only 27% of children ages 2 to 5, and 13% of children ages 6 to 9 in America had a good diet (as measured by the Healthy Eating Index).[35] Poor children were less likely to have good diets than nonpoor children.[36]

Problems related to poor nutrition and childhood obesity also have risen in recent years. Working parents may rely more heavily on fast food because of its convenience, and latchkey children are often responsible for feeding themselves and their younger siblings.

Promising Solutions

Supplemental Nutrition Programs

The Special Supplemental Food Program for Women, Infants and Children (WIC) provides food, nutritional education and screenings, and referrals to health care services for low-income women, infants, and children up to age 5. WIC participation has helped to increase birthweight, prevent preterm delivery, increase intakes of nutrients, improve rates of childhood immunization, improve growth rates,[37] and reduce Medicaid costs. WIC participation also has been associated with some cognitive gains.[38] In total, every dollar spent on WIC results in $3.50 in savings through reductions in preterm and low birthweight infants.

Although WIC provided benefits to more than 7 million women, infants, and children in FY 2000, it failed to reach 19% of those eligible.[39] Steps must be taken to ensure that eligible individuals receive these important benefits.

The School Lunch Program reaches 82% of those children eligible for free lunch and 71% of those eligible for reduced-price lunch.[40] Child nutrition programs provide nutritious meals and snacks to low-income children in schools and in other settings. Students participating in the School Breakfast Program earn higher test scores, arrive tardy less often, and have fewer absences.[41] Evaluations also suggest that children who participate in WIC and school lunch programs do better on standardized achievement tests, have better records of school attendance, and need fewer special educational services.[42] As a result, participation in the Child and Adult Care Food Program by child care centers, family child care homes, Head Start programs, and afterschool programs has been identified as a major factor in quality child care.

Community-Based Nutrition Programs

America's Second Harvest is the nation's largest organization of emergency food providers, with a network of more than 200 food banks and food rescue programs. A host of corporations, organizations, and individuals donate food and cash for food.

In 2001, America's Second Harvest distributed 1.7 billion pounds of food to 23.3 million Americans, including 9 million children, through 50,000 charitable organizations.[43] The majority of participating food pantries, kitchens, and shelters are

MODEL PRACTICE

The Food Project of Boston's mission is to make fresh, healthful food available to those with little or no access to food. In 1999, the project grew 128,000 pounds of food. Of the food grown, 55% was donated to shelters and soup kitchens, and 5% was sold, at discounted prices, in inner-city farmers' markets. The other 40% repaid 50 shareholders of the project's Community Supported Agriculture project (CSA) in Lincoln. Much of the labor is provided by 60 teenagers hired for eight weeks during the summer to tend the land, work in Boston homeless shelters, and run two farmers' markets. The Food Project succeeds due to the commitment and support of two unique communities, one low-income (Roxbury), and one affluent (Lincoln), as well as the dedication of its visionary staff.

Available from www.thefoodproject.org.

operated by faith-based agencies, and the rest by private, nonprofit organizations. Nearly two-thirds of participating agencies operate feeding programs for children and youth, including afterschool programs, child day care programs, Kids Cafes, and summer camps for low-income children.[44]

ADEQUATE HOUSING

The Need

All families and their children need shelter–a structure, whether rented or owned, that they occupy legally, in a safe building that protects them from the elements. Housing provides vital shelter, a place for families to eat and sleep, and to care for and nurture their children. "Without a decent place to live, people cannot be productive members of society, children cannot learn, and families cannot thrive."[45] Inadequate, crowded, and costly housing contributes to an array of health, education, and social problems for children and families.[46]

Homeless children suffer from more health problems, experience poorer health status, and use emergency services to a greater extent than those with homes.[47] Homeless children have higher blood lead levels (due to the presence of lead in old and untreated housing stock), higher inpatient pediatric admission rates, delayed immunizations, poorer nutritional status, heightened family food insecurity, greater developmental delays and lower school attendance.[48]

The Challenge

In 1999, 35% of all U.S. households (both renters and owners) with children reported one or more housing problems, including inadequate or crowded housing, or housing that cost more than 30% of family income. *Inadequate housing* includes housing with moderate to severe physical problems. Housing is defined as *crowded* if there is more than one person per room.[49]

As the affordable housing market all but disappeared in the late 1990s, middle-income families paid a higher percentage of their income for housing, and more low-income families struggled to find and keep an affordable place to live. In 1999, more than 1 in 10 households with children (11%) reported paying more than half of their income for housing.[50] The National Low Income Housing Coalition reported that "in no local jurisdiction in the United States can a full-time minimum-wage worker afford Fair Market Rent (FMR) for a one-bedroom unit in their community."[51]

Poverty and lack of affordable housing are the principal causes of homelessness among families with children.[52] Each year, thousands of children are separated from their families or unable to leave foster care because their parents are homeless, live in inadequate housing, or are displaced due to domestic violence.[53]

Although no regularly collected data exist on the number of homeless children in America, an estimated 1.35 million children are homeless during a year's time[54] and more than 40% (540,000) of homeless children are younger than 5.[55] These proportions are likely to be higher in rural areas.[56]

A 1998 survey of 30 U.S. cities found that one-third of requests for shelter by homeless families were denied due to lack of resources.[57]

Promising Solutions

To address the problem of homeless children and families, more resources and better coordination of existing resources are needed. Since it costs more to maintain families in homeless shelters than to help them stay housed, prevention is the key.

- *Homelessness prevention programs* provide legal assistance to tenants faced with or involved in eviction procedures and financial assistance to enable tenants to pay back rent.[58] Other services include case management, volunteer assistance, landlord/tenant mediation, and, if housing is lost, assistance with re-housing without requiring a homeless shelter stay.[59]
- *Shelter and homeless services* provide different levels of services and shelter for homeless and precariously housed families -prevention, emergency shelter, transitional housing, and permanent supportive housing (service-enriched housing). Children and youth residing in homeless shelters need to have easy access to quality early intervention programs, education, and quality medical care.
- *The Housing Choice Voucher Program* (formerly Section 8) is the primary federal program assisting very low-income families to afford adequate housing in the private market. Local housing programs can assist poor families to gain economic security and stability through the provision of and linkage to supports and services, such as education, training, health care, counseling, and child care.[60] Unfortunately, this program now reaches only one-fourth of the 15.8 million eligible households,[61] and the Low Income Home Energy Assistance Program, which helps families with their energy bills, reaches only 9% of eligible families.
- *The Family Unification Program* (FUP) provides rental subsidies to families with children who have been placed or are at risk of placement in foster care primarily because the family lacks adequate housing. FUP enables families to move into more adequate housing by subsidizing their rent through the Housing Choice Voucher Program.
- *Minnesota's Family Homeless Prevention and Assistance Program* (FHPAP) addresses homelessness by providing state funds, including TANF block grant dollars, used by counties and community nonprofit organizations to help families remain in their homes, to rehouse those who become homeless, and to shorten the length of time families spend in shelters.

  HUD's Moving to Opportunity demonstration project found that families' relocation from high to low poverty neighborhoods, creating *mixed income neighborhoods*, is associated with reduced welfare receipt, increased feelings of neighborhood safety, decreased victimization, lower incidence of injuries and asthma attacks among children, and fewer child behavior problems.[62]
- *Programs that assist low-income families to purchase and maintain homes* provide pre- and postpurchase financial assistance, and offer counseling and training in home maintenance

MODEL PRACTICE

In an Emeryville, California, neighborhood, **Doyle Street Cohousing** transformed an existing warehouse into a 12-unit community with 2,100 square feet of common facilities. During the community's seven years of occupancy, its residents have played an active role in the surrounding neighborhood, including organizing community meetings, sitting on city committees, working on graffiti clean-up at the neighborhood park, and supporting a member's campaign for City Council. The Doyle Street Cohousing community hosts numerous neighborhood meetings to exchange information and provide opportunities for debate and discussion. The community also has helped to catalyze other neighborhood revitalization projects in the immediate area, such as a bilingual Montessori School, several live-and-work projects, and the building of new office space.

McCamant, K. M. (2002). *Cohousing communities: A model for reinvigorating urban neighborhoods.* Available from www.newvillage.net/Urbaninfill.html. Information also available from www.emeryville-cohousing.org.

and foreclosure prevention.[63] Such programs show low default rates,[64] and require multiple funding sources, deep subsidies, and long-term partnerships among community groups, financial institutions, foundations, government agencies and private nonprofit organizations.[65]

- Since 1976, *Habitat for Humanity* has built more than 120,000 homes worldwide, including over 36,000 homes in the United States. The program uses "sweat equity," motivated volunteers, and a revolving loan fund capitalized with grants and contributions. In local efforts, such as the Salisbury Neighborhood Housing Services in Salisbury, Maryland, high school students build homes for low-income families.
- *Co-housing* is an emerging trend that has the potential to expand home ownership among low-income families. It provides the privacy of an individual household along with shared facilities such as a community dining room, children's playroom, workshops, guestrooms and laundry facility that provide opportunities for shared child care, social contact, and economic efficiency.[66]

A HEALTHY START

The Need

A healthy start for children includes a healthy birth, proper neonatal care, and immunizations. Adequate prenatal care increases the likelihood of a healthy birth outcome, and adolescent childbearing decreases the chances that a child will be born healthy.

Low birthweight (less than 5.5 pounds) is a major factor in infant mortality, with the risk of mortality inversely related to birthweight. Babies born at very low weights (less than 3.5 pounds) are at increased risk for developmental disabilities, congenital anomalies, illness, and later behavior problems. The effects of low birthweight also include increased hospital stays, frequent school absences, higher rates of learning disabilities, poor school performance, and behavior problems.[67]

Several factors are known to contribute to the incidence of low birthweight, including inadequate prenatal care, very young childbearing, smoking, substance abuse, and other risk behaviors.[68] Appropriate prenatal care can address maternal risk factors that affect pregnancy outcomes, such as anemia, diabetes, smoking, and poor nutrition. Adolescents bearing children are less likely to give birth to healthy babies,[69] but adequate prenatal care increases the probability of a healthy birth outcome.

Childhood vaccines protect children against diseases that can result in disability and death. Vaccines have proven enormously cost effective, averting the costs of doctors' visits, hospitalizations, disabilities, premature deaths, and additional economic costs for parents and other caregivers, who can avoid losing time at work. According to the Institute of Medicine, every $1 in vaccines saves $10 in later health care costs.

The Challenge

Although the rate of prenatal care has increased and the adolescent birthrate has decreased, the rate of babies born at low birthweights has continued to rise.

Low Birthweight

The rate of infants born at a low weight has increased slowly but steadily since 1984. In 2000, 7.69% of U.S. infants were born at a low birthweight, the highest rate since 1973; the 2000 rate for black non-Hispanic infants was 13.1%.[70]

Prenatal Care

The percentage of births to women whose prenatal care began prior to their third trimester of pregnancy increased substantially during the 1990s to 96.4% in 2000.[71] Although the rate of prenatal care improved for mothers in all ethnic groups, disparities exist: 2.3% of white mothers, 6.3% of Hispanic mothers, 6.7% of black mothers, and 8.6% of American Indian mothers received no or late prenatal care in 2000.[72]

Adolescent Childbearing

Adolescents are usually ill prepared physically, psychologically, or economically to take care of themselves, much less to take on the responsibilities of parenthood. These young mothers are more likely to drop out of school, need public assistance, and spend more years on welfare over their lifetimes.[73]

In 2000, the adolescent birthrate was at a record low, at 27 births per 1,000 young women ages 15 through 17.[74] Between 1991 and 1999, the birthrate for black, non-Hispanic adolescents dropped by 40%, and the birthrate for white, non-Hispanic teens decreased by more than one-third.[75]

Although birthrates for American teens have been declining, the United States still has the highest rates of teen pregnancy and births in the western industrialized world.[76] In the United States in 2000, adolescents ages 15 through 17 had 157,209 births.[77]

Immunizations

In 2000, 76% of children ages 19 to 35 months received the recommended doses of four key vaccines, and an additional 17% received three of the four.[78] Poor children had lower rates of coverage than nonpoor children (71% vs. 78%).[79]

MODEL PRACTICE

Nurses in the **Nurse-Family Partnership** provide comprehensive and intensive home visitation during a woman's pregnancy and throughout the first two years after the birth of her first child. The goals are to improve the health and development of both mother and child. In addition to home visitation, the program depends upon a number of other community health and social services to achieve its goals.

Compared to control groups, nurse-visited women had significantly more positive long-term outcomes, including 79% fewer verified reports of child abuse or neglect, 31% fewer subsequent births, 69% fewer maternal arrests, and 30 months less receipt of AFDC. The nurse-visited children showed significantly fewer arrests, less running away, and less alcohol consumption by age 15.

Savings to the government resulting from avoidance of negative outcomes significantly outweighed the cost of the program.

Olds, D., Hill, P., Mihalic, S., & O'Brien, R. (1998). Blueprints for violence prevention—book seven: Prenatal and infancy home visitation by nurses. Boulder, CO: Center for the Study and Prevention of Violence.

Promising Solutions

Health policies and programs for mothers and babies have had dramatic success in reducing morbidity and mortality, but their quality and accessibility continue to vary widely.

Parents and other caregivers are key partners in getting children's basic needs met, but they must know what's needed and why, the resources available, and how to access them. Many service efforts have recognized that parent education and involvement is fundamental to successfully preventing and responding to children's health care issues.

Community-Based Programs

Four Healthy Start Initiative demonstration programs were associated with a higher percentage of women in at-risk communities receiving adequate or better prenatal care and three programs were associated with significantly lower rates of low birthweight babies than their comparison sites. Although each demonstration program had a great deal of flexibility, researchers found that the characteristics of the most successful programs included: strong program organization with stable leadership, a focus on service coordination with close links to the existing clinical care systems, and community involvement through the employment of community residents.[80]

Intensive prenatal and postnatal services delivered through nurse home visitation, in conjunction with access to health and social services have also proven effective.

Sex Education and Adolescent Pregnancy Prevention

Pregnant teens confront special health challenges and risks that "require a comprehensive and coordinated array of medical care, linked with community-based services."[81]

Immunizations

To ensure that children are getting immunized, health care professionals and public health leaders have provided well-baby and well-child pamphlets, websites, and other information resources. Many emphasize the importance of immunizations and call for more education. These efforts, which have been concentrated through intensive public education campaigns conducted with health care providers, have increased awareness about the value of immunization.

MODEL PRACTICE

The comprehensive, rigorously researched **Children's Aid Society-Carrera Program** has significantly delayed the onset of sex for girls, increased the use of condoms and other effective methods of contraception, and reduced pregnancy and birthrates. "The program...includes many components: (1) family life and sex education; (2) individua academic assessment, tutoring, help with homework, preparation for standardized exams, and assistance with college entrance; (3) work-related activities, including job club, stipends, individual bank accounts, employment, and career awareness; (4) self-expression through the arts; (5) sports activities; and (6) comprehensive health care, including mental health and reproductive health services and contraception." The program was not shown to reduc sexual risk taking among boys.

Children's Aid Society. (2003). *Evaluation results from the Children's Ai Society Carrera Teen Pregnancy Prevention Program.* Available from ht /www.childrensaidsociety.org/388/?art=8257.

HEALTH AND HEALTH CARE COVERAGE

The Need

Children need sound physical and mental health and access to health care insurance coverage throughout their development. Being in good health makes many other things possible from birth across the life span. Access to appropriate and affordable health care with early detection and treatment of problems, knowledge about disease prevention and health promotion, and healthy daily living practices all contribute to a foundation of good physical and mental health.

Advances in research and practice underscore the critical importance of children's mental health to their overall well-being and healthy development. Similarly, the mental health status of parents and other caregivers influences the conditions and opportunities that children face.

The Challenge

Health and Mental Health

In 2000, parents reported that 82% of their children were in very good or excellent health.[82] Reported child health status, however, varied by income. About 70% of children and youth living below the federal poverty line were reported as being in very good or excellent health as opposed to 85% of children in families living at or above the poverty line.[83]

Mental disorders and mental health problems appear in families of all social classes and backgrounds. At any given time, at least 1 in 5 children and adolescents may have a mental health problem, and at least 1 in 10–as many as 6 million children–may have a serious emotional disturbance.[84] Of these, about half have problems that are severe and persistent.[85]

A broad array of factors, including physical and intellectual disabilities, low birthweight, family history of mental and addictive disorders, multigenerational poverty, and abuse and neglect place children at heightened risk for mental health disorders.[86] Problems that predominantly affect poor children (e.g., violence, exposure to high levels of lead, stress related to

chronic poverty and discrimination, and loss of important people) increase their chances of developing mental health problems.

Children with untreated mental health problems may be self-abusive, aggressive toward others, withdrawn, fearful, or depressed. Some children with the most serious disorders may have unusual fantasies or hallucinations that make it extremely difficult for them to learn or develop socially.

An estimated two-thirds of children with mental health problems are not receiving services.[87] Their parents and other adults in their lives may not recognize the signs of mental health problems. Available services too often are inaccessible or do not reflect the cultural values and concerns of the families they are meant to treat. Also, parents may not be able to meet the staggering costs for special treatment, education, or other services that their children may require.

When children's mental health problems go untreated, the children and their families may suffer serious personal, social, and economic difficulties. Families without appropriate child care may become isolated from friends and relatives, and may have difficulty meeting employers' demands. Family members may not know how to cope with the difficult and demanding behaviors of their children.[88] Siblings of children with chronic mental health problems are more likely to exhibit behavioral problems themselves.[89]

Health Care Coverage

Nearly 8.4 million children—approximately 12% of all children—lack health insurance coverage and have limited or no routine primary and preventive care.[90] They do not regularly visit the doctor, nor do they routinely receive care for a variety of acute health problems (e.g., sore throats, urinary tract infection, or injuries), and chronic conditions (e.g., asthma, obesity, and developmental delays). They and their families do not receive health-promoting information, screening, and other prevention-focused interventions. One in five uninsured children has no regular source of health care.[91]

Many parents also have no health insurance coverage for themselves. Others have plans with benefits that fail to adequately cover their own health care needs and exclude their children altogether.

Promising Solutions

Local, state, and national policies directed at the health of children, youth, and families have had a mixed impact on their well-being.

Medicaid

Medicaid (Title XIX of the Social Security Act), the major health care program for the poor, covered 23% of children in America in 2001.[92] The number of children who rely on Medicaid for coverage has grown due to the loss of private health insurance and the intentional expansion of Medicaid coverage to children in families with incomes above the poverty line.

This public program, although limited and uneven in benefits, provides access to prenatal care, well-baby checkups, and other critical services that help to ensure good beginnings for children and families. The preventive care provided by Medicaid also reduces the likelihood that children will be hospitalized.[93]

State Child Health Insurance Program (SCHIP)

Many uninsured children are not covered by Medicaid because their working poor parents do not meet eligibility criteria. Enacted in 1997, the State Child Health Insurance Program (Title XXI

of the Social Security Act) provides federal matching funds that states may use to provide insurance coverage for uninsured low-income children who are not eligible for Medicaid or private insurance coverage. Preliminary evidence demonstrates that CHIP improves children's immunization rates, anemia, lead-level, use of preventive care, and vision, and hearing screenings.[94]

Mental Health

Service providers working in a coordinated fashion with caring families and communities can recognize and treat children with mental health problems. Such efforts start with education so that parents and adults recognize the symptoms. Recognition must be followed by elimination of the stigma associated with mental health problems and access to quality services. A culturally appropriate system of care that integrates a range of services and focuses on the strengths of young people and their families can have a significant positive impact on a child's mental well-being.

MODEL PRACTICE

The mission of the **Mesa County Early Childhood Partnership,** a collaboration of 17 agencies, is to create and sustain a resource rich community for all families so that young children reach their full potential in safe and optimally nurturing environments. One of their goals is to ensure quality and accessible medical and dental coverage for all children in the county. Their efforts have resulted in the enrollment of 92% of all eligible children in CHIP, compared to a Colorado statewide average enrollment of 9%.

For more information, contact Janet Rowland, Public Information Officer, Mesa County Department of Human Services at 970/256-2453 or e-mail janet.rowland@mcdss.co.gov.

MODEL PRACTICE

Colorado has taken a unique approach to addressing children's mental health issues in a cross disciplinary fashion. An early intervention pilot supported by the Colorado General Assembly provides early childhood mental health specialists to work on site at childcare and Head Start sites. Results from the pilot sites showed reduced childhood expulsions and increased behavioral management capacity on the part of teachers and assistants.

EDUCATION

The Need

Acquiring a basic education means learning the fundamental reading, writing, and mathematics skills needed to function in society. In the United States, this entails earning a high school diploma or an alternative credential, such as a GED.

A high school diploma is required for many entry-level jobs and is a prerequisite for higher education. Education has provided opportunities for a better life for generations of U.S. children and their families. A sound educational foundation leads to success for children in school and beyond. By contrast, children and youth with academic problems that lead to truancy or dropping out are more likely to become involved in delinquency.[95]

The Challenge

More Americans than ever are graduating from high school. In 2000, 87% of young adults ages 18 to 24 had completed high school, either with a diploma or an alternative credential, such as the GED. This represents a 4% increase since 1980.[96] Two-thirds of employers surveyed in 1999, however, said that most high school graduates do not have the skills necessary to succeed in the workplace.[97]

In 1999, the National Assessment of Educational Progress, which measures national trends in academic performance, found that average reading scores of students ages 9, 13, and 17 had not improved since 1980.[98]

American youth do not perform as well overall as their counterparts abroad. American 12th graders scored among the lowest of 21 nations examined in 1998 by the Third International Mathematics and Science Study.[99] An examination of factors that might affect the performance of American teens found that common U.S. practices such as tracking or providing

different courses to different kinds of students did not exist in countries that excelled.[100] Furthermore, U.S. high school seniors spent fewer hours doing homework and more in paid employment than students in other countries.[101]

A significant and persistent achievement gap exists between white students and students of color, and between students from schools in affluent communities and those from poorer communities with underfunded schools. For example, in math, studies indicate that, on average, skills of minority children lag two years behind their white counterparts.[102]

For children in new immigrant families, the challenges of realizing success through education may require learning a new language while mastering basic academic and social skills. For many such children, this task is even more challenging if their parents have only limited English proficiency and/or limited literacy in their native language.

Promising Solutions

Excellence in Schools

Offering all children and youth a quality basic education means providing them with the knowledge and skills that are critical for success, advancing effective educational models and teaching methods, and deploying approaches that address the range of capabilities, learning needs, and life experiences that children bring to school. In recent years, new and sometimes controversial educational policy initiatives (e.g., standardized testing, charter schools, and voucher programs) are being tried to improve performance.

To succeed, schools must offer challenging academic, vocational, and technical programs to meet a broad range of educational needs. Programs for developmentally disabled children, gifted and talented children, and children for whom English is a second language must be available and accessible. Educational success also depends upon reasonable class size, as well as access to adequate books, computers, and other resource materials.

Teachers who are well-trained, adequately supported, and competent are needed, as are school principals and superintendents who provide strong leadership and develop partnerships with parents and communities. Other efforts shown to improve educational outcomes for children include afterschool activities and field trips, and school-based conflict resolution, mediation classes, and services.

For children with limited English proficiency, two-way bilingual education programs foster high levels of skill in both a first and second language along with academic achievement that is at or above grade level.[103]

MODEL PRACTICE

The **Key Elementary School in Arlington, Virginia,** is one of several two-way bilingual schools cited for its accomplishments. Students have shown year-to-year improvements in Spanish and even faster development in English proficiency. Fourth-graders scored at the fifth- or sixth-grade level on vocabulary, reading comprehension, science, social studies, and math subtests on the Iowa Test of Basic Skills.

Christian, D. (1994). *Two-way bilingual education: Students learning through two languages. Educational Practice Report 12.* Santa Cruz, CA, and Washington, DC: National Center for Research on Cultural Diversity and Second Language Learning.

Community Schools

Community schools, also called "full-service" or "extended service" schools, are emerging across the country and providing an up-to-date variation on an old theme: providing places where children, youth, and families can come together for social, recreational, educational, and lifelong learning activities. Community schools forge effective partnerships among schools, families, and other community resources to promote children's learning and development.

Community schools offer a variety of activities during school days, and during afternoons, evenings, and weekends that build on the unique strengths and resources of the community to pro-

vide a place of support and growth for children and their families.[104] Though services and program design varies, community school programs across the country are reporting improvements in learning, youth development, family well-being and community life.[105]

Parental Support of Learning

Parents play a key role in their children's academic success. Throughout the school years, parents can support their children by setting up predictable homework routines, showing interest in school performance and activities, and building collaborative relationships with teachers.

Tutoring and Mentoring

Tutoring and mentoring programs that provide adult role models can help children and youth learn more about who they are and what they can be. The Pew Partnership found that the benefits for at-risk youth of high-quality one-on-one mentoring by adults include improved academic performance, more participation in college-preparatory activities, increased likelihood of attending college immediately after high school graduation, and remaining longer in college.[106]

Tutoring and mentoring by peers also encourages children to master their schoolwork and to develop the skills they need to succeed. "Through peer programs, kids see the importance and value of the contributions of their equals. Seeing that their classmates are capable of giving wisdom and guidance can encourage children to believe in their own ability at their age level to solve problems successfully."[107]

Although the challenge is daunting, meeting every one of these basic needs for every child must be the goal of each community in America. No parent would accept anything less for their own children, and we, as a country, cannot accept less. In each instance, the research tells us that we will recoup our investments many times over in reduced social costs during the lifetime of these children–and at the same time we will create a safe and nurturing environment in which children will thrive.

MODEL PRACTICE

At the **Children's Aid Society (CAS) in New York,** a partnership with the New York City Board of Education brings parents, teachers, and community members together as full partners in nine community schools located in elementary, middle, and high schools around the city. Each provides resources such as academic enrichment, sports, health and social services, arts, community service, and community development.

A three-year outcome study by Fordham University documented improved academic achievement, increased student and teacher attendance, improved school climate and school safety, dramatic increases in parent involvement, and improved student-teacher relationships.

Children's Aid Society. Available from www.childrensaidsociety.org.

MODEL PRACTICE

Class Wide Peer Tutoring (CWPT) at the Juniper Gardens Children's Project at the University of Kansas, is a community-based program devoted to improving the developmental outcomes of children who live in low-income areas. Using reciprocal peer tutoring for children in kindergarten through sixth grade, this model has resulted in higher math and reading test scores than those of control groups, and increased ability to stay on task, to remain engaged with their lessons, and to respond to the teacher.

By the end of the fourth grade, students who began CWPT in the first grade scored more than 11% higher on average than control groups in both reading and math on a nationally standardized test, after test scores were adjusted for differences between the two groups, such as measured IQ, that were determined in the first grade.

Promising Practices Network. (2002). *Proven and promising practices.* Available from www.promisingpractices.net.

Relationships

eva Dunbar's days are a
f snowsuits, snacks, and
action problems. From
morning, when she
s three children for
l, to nightfall, when she
them into bed, she is like
one-weary, two-hands-
enough, mother.
e difference is that Mrs.
ar, age 51, has already
her own children and
hem off to college and
usiness world. But when
aughter died in the attack
e World Trade Center, Mrs.
ar found herself part of a
rmy of grandparents
into a second round of
rearing.
's not what I planned,"
Mrs. Dunbar, of Brooklyn,
e 31-year old daughter,
Taylor, was an insurance
r at Marsh & McLennan.
hard for me. But I'm so
y to be able to help in
ay I can."
, she gulps back tears
...lmani, playing with a
lephone, says she is
g heaven and passes the
er to her reluctant
lmother. "Hey, Ris," Mrs.
ar says, using her
nter's nickname and
ng merriment, "I'm
g care of your babies."

The New York Times,
February 8, 2002

For children who experience the loss or incapacity of a loved one their sorrow can only be tempered by the tremendous love and commitment of grandmothers like Mrs. Dunbar, and other relatives and caregivers, who respond to children's needs without reservation, even in the face of untold challenges. We know that the importance of these relationships is immeasurable. They not only meet the immediate needs of children experiencing a crisis, they also provide a long-term, loving environment that will help children to cope more effectively with their losses.

Close nurturing relationships are not only important in times that test us, they are critical every day for every child. "Relationships ... are the building blocks of healthy development",[108] helping to assure that children from infancy to young adulthood have the guidance and support they need to successfully master life skills. All children need a continuous relationship with a consistently attentive and caring adult–someone who loves them unconditionally and who stimulates, nurtures, and treats them as special.[109]

Beginning with the pivotal role played by parents and caregivers who love, nurture, teach, and protect children, these critical relationships are augmented by those with grandparents, aunts and uncles, neighbors, teachers, mentors and other adults who give added joy, support, and direction to children. Children also gain from their relationships with other children, including their siblings, cousins, and peers. These relationships can help to enhance what is gained from adults so that children learn to work together, manage conflict, and test new skills.

Nurturing relationships, however, do not happen in isolation. They form, grow, and are affected by life events and by the families and neighborhoods within which they occur. Though there are many commonalities that make us distinctively American, we still enjoy diverse values, differing religious beliefs, and varied national and ethnic heritages that influence the way we nurture and care for our children.

The last 50 years have brought significant changes in the way that families form and function. Although most children still live with two parents throughout much of their childhood, many experience other living arrangements.[110] Understanding these family arrangements helps us to appreciate and nourish the healthy relationships that children have.

NURTURING RELATIONSHIPS WITH PARENTS

The Need

Close nurturing relationships between parents and children provide critical pillars for healthy development and learning. Parental relationships–whether with stepparents, kin, birthparents, or adoptive parents–are a fundamental resource for children that fills several core functions. Parents meet the basic needs of their children, providing the food, clothing, care, and supervision needed to keep them healthy and safe. Parents also help children in more subtle but equally important ways, soothing feelings when disappointment or discomfort overwhelms both toddlers and teens.

BEST COPY AVAILABLE

Parents help children form relationships with friends, neighbors, and peers. They teach concrete skills and, by example, impart moral and ethical lessons every day. Throughout childhood and into young adulthood, parents help their children feel valued and accepted.[111] Although their functions are complex, their activities seem quite simple—talking, holding, reading, singing, listening, showing, encouraging, guiding, protecting, laughing, and letting go.

These hands-on actions and the complex caregiving relationships they reflect are children's first and primary contexts for the experiences and accomplishments that follow. Secure attachment to a caregiver reduces a child's fear and the stress of new and challenging situations, and enables exploration to occur with confidence. "Across all cultures, children form attachments and use parents as sources of security and comfort. Without relationships of this kind, in extreme cases, children may not survive or may experience serious developmental problems."[112]

When parents are sensitive and responsive, even temperamentally difficult infants develop secure and trusting relationships.[113] "Toddlers fostered or adopted from conditions of extreme neglect have been found to adjust over time, showing behaviors that reflect their secure expectations of support and comfort as they adapt to foster or adoptive parents who provide sensitive, responsive, and consistent care."[114]

The basic competencies children achieve through relationships with their parents and caregivers can help them adapt to life's challenges by building their capacity for hope and a positive outlook, self-esteem, sense of independence, social network, and special skills and interests.[115]

Although increased independence and separation mark adolescence, a close parent-child relationship remains important. Youth whose parents permit them to work toward separation while maintaining continued family closeness experience greater maturity and less risk taking.[116] They are less likely to engage in problem behaviors like drinking, experimenting with other drugs, and delinquency[117] that can compromise their health, their future, and their lives.

Adoptive families provide care and permanence for many children who are unable to live with their birthparents. Children and youth are adopted through the child welfare system as well as by stepparents and other relatives, and through intercountry adoptions, independent adoptions, and adoptions through private agencies.

The Challenge

In 2000, 69% of American children lived with two parents. About one of every five (22%) children lived with only their mothers; 4% of children lived with only their fathers.[118]

Working Parents

A nationwide study in 1997 found that two in five parents of children under age three said that they did not spend as much quality time with their children as they would like.[119] When mothers work outside the home, parents may worry that too much time away from family may have a detrimental affect on children's health, behavior, or school performance.

A fulfilling career, however, can improve a mother's ability to build strong relationships with her children.[120] As more women have entered the workforce, more fathers are taking an active part in the care of their children, although mothers still carry the bulk of childrearing responsibilities.[121] Finding a balance that meets the financial, family, work, and personal needs of parents and children can be a continuing struggle.

Marital Disruption

One-third of children will see their parent's marriage disrupted[122] and half of them will see a parent divorce again within ten years.[123] Although the majority of children of divorce do well,

many experience negative consequences. Studies of divorcing families have found that in half of the families, divorced parents stayed angry with each other;[124] three in five children felt rejected by one of their parents;[125] and one in four children saw a serious decline in their standard of living following the divorce.[126] An estimated 78% of fathers living away from their children paid child support, but only 30% visited their children regularly.[127] Most children did not receive help with college from their noncustodial fathers, and many received no financial aid for college because their father's income was too high.[128] A meta-analysis of 92 studies involving 13,000 children ranging from preschool to young adulthood indicated that children from divorced families are on "average" somewhat worse off than children who have lived in intact families.[129] Children of divorced parents are more likely to have difficulty in school, behavior problems, negative self-concepts, problems with peers, and trouble getting along with their parents. Evidence suggests that the loss of parents, economic difficulties, stress, parental adjustment and competence, and interparental conflict all contribute to the problems faced by children in divorcing/divorced families.[130]

Maternal Depression

Maternal depression is a growing concern. Too many families are affected by mental illness, child abuse and neglect, and domestic violence. One study found that 30% to 50% of mothers of young children experience minor depression.[131] Poverty, poor health, drugs, and alcohol can alter the ability of parents to provide children with close nurturing relationships.

Adoption

During FY 2000, approximately 51,000 children from the child welfare system were adopted, a 98% increase over the 25,693 adopted in 1995.[132] While no accurate statistics exist, it is estimated that tens of thousands of children who are not in the child welfare system are also adopted in the United States each year.[133] On March 30, 2000, 131,000 children in the child welfare system were waiting for an adoptive home, but had not yet been placed in adoptive homes.[134]

Promising Solutions

Family Support Programs

Family support programs emphasize the prevention of child abuse and neglect, and provide training and other services that can help parents become more effective caregivers for their children. Programs engage family members in improving their communication and conflict resolution skills, and their knowledge of child development.

Family support programs also offer parents opportunities to participate in activities with their children and with other parents, and assist them in addressing their specific family concerns. Evaluations have concluded that family support programs "can produce positive changes in parenting behavior and skills, parent-child relations, and some aspects of family self-sufficiency."[135]

MODEL PRACTICE

The **Caroline County Family Support Center** serves pregnant and parenting adolescents, families with low incomes and low birthweight babies, high school dropouts, and the unemployed or underemployed in rural Caroline County, Maryland. Center and home-based services, made possible by a local collaboration include developmentally appropriate child care when parents are at the Center, adult education and employability services, peer support, health education and referral, developmental assessment and referral, and service coordination and outreach.

Parents are treated as equal partners, share in policy decisions and program development, and comprise more than 51% of the active governing board. Goals are tailored to families' strengths and needs, and progress toward these individualized goals is the primary measure of success. The Center also looks at the extent to which children are meeting developmental milestones, and whether they are getting any assistance they might need to meet these goals.

Program results include improved parenting behaviors and attitudes and regular health care providers and health care coverage for all children and parents. No "graduates" of the program are known to have become involved with the child welfare system, and numerous parents have obtained full-time employment, graduated from high school, or gone on to a higher education setting.

See www.friendsofthefamily.org

Support for Children of Separation and Divorce

Families may participate in counseling, divorce education, or use mediation to better transition out of a failing marriage. Programs that offer comprehensive legal and social services can provide parents and children in separating or divorcing families with support during this stressful time.

Adoption

Adopted children fare much better than those youngsters who are reared in institutional environments or in foster care.[136] Adopted youth do significantly better than children raised by their birthparents who are ambivalent about caring for them or who do not want them.[137]

Adoption is likely to be most successful when adoption agencies assist families to obtain early compensatory education services for their adopted children,[138] and offer flexible longer-term post-adoptive services.[139]

MODEL PRACTICE

The **National Family Resiliency Program** offers parents a nonadversarial and supportive way to guide their children through the challenging, painful, and often confusing process of separation and divorce. NFRC mental health professionals, judges, attorneys, mediators, educators, and specialists in the community provide a constellation of services at one location to help the family make child-focused decisions and to ensure loving, healthy relationships between parents and children.

Through an individually-tailored program, parents are able to jointly maintain control over decisions that affect their children, rather than giving up that right to total strangers, lawyers, and judges; avoid the significant and long-lasting financial and emotional costs of traditional separation and divorce procedures; focus on behaviors and actions that are truly in the best interest of their children; and begin the healing process and move on with their lives.

National Family Resiliency Center, Columbia, Maryland. See www.divorceabc.com/default.htm.

NURTURING RELATIONSHIPS WITH KIN

The Need

Grandparents often bring a special kind of love and attention to their grandchildren and grandmothers are an especially important source of care during the earliest months and years of life. Their support can help secure strong attachments between mothers and their infants.[140] Beyond their traditional roles, grandparents and other relatives are increasingly serving as primary caregivers for their grandchildren. Fortunately, most grandparents are healthier and likely to live longer than at any other time in our history.

Positive relationships with siblings can offer support during difficult times, and are a key factor in healthy development. Younger siblings who are befriended and nurtured by older siblings tend to develop relatively mature behavior,[141] and younger siblings can have similarly positive effects on the social behaviors of their older brothers and sisters.[142]

The Challenge

The number of children raised by relatives other than their parents is growing rapidly. An estimated 5.4 million American children are living in homes headed by a grandparent or other relative.[143] Grandparents and other kin who provide full-time care for related children can face significant financial and health challenges. Kinship caregivers must cope with the proposition of raising a second family, often in the face of emotional stress resulting from the death of the children's parents or their continued inability to provide adequate care for their children.

Although strong connections with brothers and sisters may be a child's most enduring relationships, children and youth who are placed outside of their homes due to abuse and neglect are often separated from their siblings. In 2001, almost half of the children in out-of-home care in California were separated from one or more of their siblings,[144] as was the case for nearly one-third of all children who entered out-of-home care in New York City during 1999.[145] No national data exist on this subject, and even less is known about sibling placements in adoptive homes.

MODEL PRACTICE

The **Edgewood Center's Kinship Support Network** (KSN) offers a case management program and support groups to kinship caregivers, in addition to a variety of intervention services, including a health team, mental health counseling, respite, recreation activities, training workshops, tutoring/mentoring, and transportation services.

Key elements of the KSN model include private delivery of services at a community level, sufficient oversight and control by the appropriate public agencies to ensure that mandated policies are observed, use of "community workers" from the clients' neighborhoods whose life experiences are similar to those of their clients, delivery of services at a central site, and program guidance from the community by former clients. KSN benefits kin caregivers by reducing their needs, bolstering their ability to cope, enhancing their satisfaction with support networks, and maintaining or improving their physical and mental health.

Edgewood Center for Children and Families. (2001). *Fact sheet #1: An overview of the kinship support network model.* Available from www.edgewoodcenter.org/results/stuartfactsheets.htm.

MODEL PRACTICE

Casey Family Programs National Center for Resource Family Support provides information on research, model programs, and resources on working with siblings in the child welfare system. Suggested casework practices include: introducing siblings into foster families in staggered placements; presenting sibling groups together in photolistings and recruitment campaigns; assessing resource parents for large sibling groups by looking for administrative skills, coping skills, access to community services, existence of support systems, experience with living in a large family, and willingness to value sibling ties; and assigning one worker to all siblings.

Casey Family Programs, National Center for Resource Family Support. *Ideas on siblings in out of home care.* Available from www.casey.org/cnc/policy_issues/ideas_on_siblings.htm.

Promising Solutions

Kinship Care

Children in kinship care experience more parental visits,[146] fewer placement changes,[147] and more reunifications with their families[148] than children in nonkinship foster care. Sibling groups are more likely to be placed together in kinship care than in foster care.[149]

Kinship caregivers need a variety of supports and services. State legislation and policies that provide ample financial support, and that offer acceptable ways for kin to become legal guardians are especially needed. California's SB1901, enacted in 1997, established a new custody option of kin guardianship for relatives. It also created the Kinship Guardianship Assistance Payment program (KinGAP), which provides financial assistance that is equal to foster care reimbursement rates to children whose relatives become their legal kin guardians.[150]

Placing siblings together in foster and adoptive homes and maintaining their connections with each other when they cannot be placed together can minimize the trauma of separation. Child welfare agencies can collect data on sibling placements, develop policies that require that sibling groups be placed together except in extraordinary circumstances, and provide training, resources, and incentives to workers and foster parents to support placement of sibling groups together.

NURTURING RELATIONSHIPS WITH OTHER ADULTS AND CHILDREN

The Need

Positive adult relationships beyond families help children and youth stay safe, out of trouble, and on a road to success. Older children and youth benefit greatly from relationships with caring adults, including teachers, coaches, employers, family friends, church members, and youth workers.

Relationships with peers are an important part of growing up. Typically, they allow children to be children, enjoying time for just plain fun. Peer relationships are usually the first way that children engage socially outside of the family. Most peer friendships are positive and safe experiences that provide children with opportunities to try on their skills for leading, fitting in, and negotiating with others. Children who have poor peer relationships are at risk for later life difficulties, especially school dropout and criminal behavior.[151]

The Challenge

Assets surveys by the Search Institute in communities across the country consistently show that more than three-quarters of youth do not feel that their communities value them or see

them as resources.[152] Despite continued improvements in child well-being and reductions in the rate of risk behaviors by youth, adults still sometimes display a lack of confidence in youth and in their ability to achieve great things.

Motivating adults to value, befriend, and support children and youth other than those to whom they are related can be challenging. Ongoing efforts are needed to get adults aware, interested, and involved in meeting the relationship needs of children and youth in their communities.

Promising Solutions

Positive Relationships with Nonrelative Adults and Youth

A variety of programs document the positive impacts that relationships with adults can have on children and youth. Volunteers working with children and youth should be carefully screened, adequately oriented, trained, supported, and supervised.

Several intervention programs demonstrate that youth can help their peers improve social and other lifeskills.

MODEL PRACTICE

Big Brothers, Big Sisters of America (BBBS) matches nonrelated volunteer adult mentors with children ages 6 to 18 from single parent homes to promote positive development and social responsibility. BBBS rigorously screens volunteers and provides ongoing supervision. Participating youths, as compared with control group youths, were less likely to demonstrate aggressive behavior or to initiate drug or alcohol use, and more likely to perform better in school, and have stronger relationships with their parents and peers.

Taylor, A. S., & Bressler, J. (2000). *Mentoring across generations: Partnerships for positive youth development*. New York: Kluwer Academic/Plenum.

MODEL PRACTICE

Be Proud! Be Responsible!, a Philadelphia program, uses peer and adult leaders to address sexual risk-taking behaviors among inner-city middle school youth. Program participants reported consistent condom use at three months, and higher frequency of condom-protected intercourse at all follow-up time intervals. There was less sexual activity at 6- and 12-month follow-ups among those youth reporting sexual experience, and less unprotected intercourse at all follow-ups.

Taylor, A. S., & Bressler, J. (2000). *Mentoring across generations: Partnerships for positive youth development*. New York: Kluwer Academic/Plenum.

Opportunities

ght years ago, a single
ade class in northern
rnia decided to study an
ngered species of shrimp
toring a specific piece of
rimp's habitat. Now we
a network of a hundred
s, kindergarten through
school, from 35 different
ls, working on restoring
les of creek. They monitor
quality, map habitat, keep
of bird and insect
lations, and create artwork
d to the creek. Those kids
a sense of intimacy with
lace, and it bonds them to
nother, and to the
nunity, and to the land. It's
y different experience than
g around in classrooms
alking about ecosystems.
nd the children are getting
s: the shrimp are coming
The experts told us it would
happen—or, at best, it
d happen in 50 or 100
—but, eight years later, the
p are coming back. The
atory birds are returning,
ecause we've restored the
at where they nest. A
tion that seemed hopeless
with a minimal investment
n to be remedied. And
e children have hope for
uture and have seen how
ningful their actions can be."

-Zenobia Barlow, Executive
Director, Center for
Ecoliteracy, Berkeley, CA

Opportunities to learn by doing and to see their actions make a difference can give children a sense of mastery and strengthen their connections to their peers and communities. Providing a childhood full of experiences and opportunities that motivate and equip children to succeed is the collective responsibility of individuals, families, neighborhoods, and communities.

America is often called "the land of opportunity," yet many of our children and youth do not have the opportunities they need to succeed. Ensuring that all children and youth can fully develop their potential requires us to see their development as both a goal that must be attained and a process that must be continuously supported. Simply intervening in crises and correcting problems is not enough. We must adopt the broadest possible vision of prevention–one that extends beyond efforts to reduce risks for selected "at-risk" children to encompass proactive efforts to help all children excel.

This chapter discusses what we can do to encourage children to develop their talents and skills, to contribute to their families and communities, and to make positive connections to their cultures, traditions, and spiritual resources.

OPPORTUNITIES FOR EARLY CHILDHOOD DEVELOPMENT

The Need

Children under age five need care and support to develop the cognitive, emotional, social, language, and motor skills needed to succeed in school and in life. Parents and other primary caregivers are principally responsible for providing a nurturing, safe, and stimulating environment that promotes their children's healthy growth and development. Young children are more likely to develop optimally if they have their basic needs met and participate in nurturing relationships with their parents, other family members, and friends. For example, family members reading aloud daily to young children is linked to later reading achievement, comprehension, and overall school success.[154]

Community resources such as child care providers and early childhood learning programs play an important role in enabling young children to become emotionally secure, socially competent, and intellectually capable. Higher quality child care is associated with higher cognitive performance, better language ability, and greater school readiness, in addition to better mother-child relationships, lower probability of insecure attachment in infants of mothers low in sensitivity, and fewer reports of children's problem behaviors.[155]

The role of caregivers is especially critical for children and parents who are struggling. Rather than compromising primary parental relationships, quality relationships between caregivers and children can actually help parents have better relations with their children, particularly where difficulties have existed. Research demonstrates that spending many hours in nonparental care does not undermine the child's primary relationships.[156]

BEST COPY AVAILABLE

Several longitudinal studies have found positive outcomes associated with participation in quality early childhood learning programs, include higher IQ, better learning ability and performance, improved language development, higher levels of educational attainment, and delayed parenthood.[157, 158]

Quality early childhood learning programs can also play a central role in providing parents with information and offering them opportunities to enhance their parenting skills. A Rand Corporation review[159] of nine early childhood intervention programs found major benefits for both mothers and children, including increased educational achievement, reduced levels of criminal activity, increased economic self-sufficiency, and improved health outcomes.

The Challenge

Although early childhood development and school readiness include much more than cognitive and literacy skills, these are the skills on which data are available. In 1999, an analysis of parent reports of their age 3 to 5 children's possession of four cognitive and early literacy school readiness skills indicated that 39% of their preschool children had three or four of theseskills.[160] These skills included the ability to recognize letters, to count to 20 or higher, to write their names, and to read or pretend to read.

Poor preschool children were much less likely to possess three or four of the cognitive/literacy skills (19%), compared with children living above the poverty line (45%).[161] Twenty-five percent of Hispanic 3 to 5 year olds, 35% of black, non-Hispanic children, 42% of white, non-Hispanic children, and 48% of "other" (mostly Asian) children had three or four of the skills.[162]

In 2001, 48% of poor children were read aloud to daily by a family member, compared to 61% of children above the poverty line.[163]

In 2001, over half of all children ages birth to 2 (52%) and three out of four children ages 3 to 5 (74%) spent time in formal and informal child day care settings. In 1999, however, a national study of early child care reported that, in general, the quality of day care in the United States is "fair–neither outstanding nor terrible".[164] Earlier studies found that only 9% of all family-based child care settings offered good care (defined as growth-enhancing), 56% provided adequate/custodial care (defined as growth-neutral), and 35% provided inadequate care (defined as growth-harming);[165] only one in seven centers was rated as developmentally appropriate.[166]

Although poor children have a greater need for high quality child care, they are disproportionately likely to attend poorer quality child care settings.[167] Some states have been forward thinking in setting standards concerning the quality of child care, but the federal government has not focused adequately on this issue. No restrictions are placed on states, for example, regarding the type or quality of child care provided to children of mothers moving from "welfare to work" through TANF.

Promising Solutions

Family Literacy Programs

Family literacy programs can increase parents' literacy and support them in reading to their children. This enhances the parents' academic skills and employability in addition to improving the children's readiness for school.

MODEL PRACTICE

The **Family and Child Education** (FACE) Program is a family literacy program serving American Indian families with children up to 8 years of age. It operates through 32 Bureau of Indian Affairs-funded schools. Under contract with the Bureau of Indian Affairs' Office of Indian Education Programs, Parents as Teachers National Center offers training and technical assistance for parent educators providing home-based services to families with children from birth to 3 years of age, National Center for Family Literacy supports center-based services to 3- to 5-year-olds and their parents, and High/Scope Research Foundation assists teachers in implementing the High/Scope curriculum in grades kindergarten through third.

In 60 Bureau-funded elementary schools without a FACE program, Parents as Teachers—through a program dubbed BabyFACE—offers home-based services to families throughout pregnancy and until their child enters kindergarten.

About 85% of FACE parents report increased understanding of child development, increased involvement in their child's education, more effective interaction with their child, more time spent with their child, and more time spent telling stories and reading to their child. Two of every three adults participating in FACE report that their academic skills have improved, and 75% of home-based adults and 80% of center-based adults frequently spend time reading for enjoyment or learning.

Bureau of Indian Affairs FACE/Baby FACE Programs. For information, contact Susan S. Stepleton, President/CEO, Parents as Teachers National Center, Inc.

MODEL PRACTICES

The **Perry Preschool Project,** providing half-day preschool with highly qualified teachers along with home visits, found positive effects on achievement, grades, high school graduation rates, and earnings. It also found participation associated with lower crime and welfare use at age 27. The Project dramatically demonstrated that investment in high-quality child care and family support pays off with significant long-term savings. Savings to the government resulting from avoidance of negative outcomes amounted to more than double the program's costs per child ($25,000 versus $12,000).

The **Abecedarian Project,** a full-day program from birth to age 5 with follow up intervention for school-aged children, found that children receiving preschool services had a lower incidence of special education needs and grade retention. At age 21, they were twice as likely to still be in school or to have attended college.

Schweinhart, L. J., Barnes, H.V., & Weikart, D. P. (1993). *Significant benefits: The High/Scope Preschool Study through age 27* (Monographs of the High/School Education Research Foundation, #10). Ypsilanti, MI: High/Scope Press; Karoly, Greenwood, Everingham, Houbé, Kilburn, Rydell, et al. (1998), op. cit.; Pew Partnership for Civic Change. (2001). *Wanted: Solutions for America. What we know works.* Charlottesville, VA: Pew Partnership. Available from http://www.pew-partnership.org/familieschildren/youthdev/afterschool.html.

Child Day Care and Early Childhood Learning Programs

Ways to improve child day care quality include increasing the ratio of caregivers to children, lowering group sizes, increasing caregivers' levels of education, and increasing safety and intellectual stimulation.[168] Studies have also found that child care providers who are regulated by their states are more likely to be sensitive and responsive, and to offer adequate to good care,[169] and that "states with more demanding licensing standards have fewer poor-quality centers."[170]

According to the Academy for Education Development and Center for Law and Education, successful comprehensive preschool programs:[171]

- Reach out to homes and neighborhoods where families live;
- Provide medical checkups to pregnant women;
- Hire parent educators who show parents how to help their children learn by reading, playing, and talking with them;
- Offer childcare for young children and older brothers and sisters;
- Prepare children for school and assist with their passage to kindergarten;
- Help parents talk freely to teachers and school officials; and
- Provide adult education and job training so parents can earn a high school diploma and secure employment.

A Rand Corporation review[172] of nine early intervention programs dramatically demonstrated that investment in high-quality child care and family support pays off with significant long-term savings. Since these programs have produced proportionately greater benefits for disadvantaged children, it suggested that "where budgets are limited, it is appropriate to target early intervention to the most disadvantaged children."[173]

OPPORTUNITIES FOR DEVELOPMENT OF SCHOOL-AGE CHILDREN

The Need

Growing children need opportunities to explore and develop their skills and talents, whether they include kicking a soccer ball, writing a poem, or playing the tuba. The developmental needs of elementary and middle school children include physical activity, competence, achievement, self-definition, creative expression, and social interaction. These needs are met at home through writing, leisure reading, homework, chores, hobbies, and games. They are

also met through school, faith-based, and child care activities, and through organized enrichment activities such as sports, arts, clubs, and tutoring.

Extracurricular activities can improve social and academic outcomes. Afterschool programs can provide enriching social, recreational, and academic experiences where children have previously been unsupervised. Positive outcomes include improved school performance and attendance, improved social skills and self-confidence, and a healthier use of time.[174]

Growing up means exploring the many dimensions of culture that help children and youth to form their own identities. Although we typically view culture as driven by ethnicity, race, or linguistic background, culture extends well beyond these dimensions to include those values, ideas, traditions, behavior patterns, arts, and faith that define who we are. Parents can help to create positive cultural connections for their children by providing them with opportunities to learn family and cultural traditions from grandparents and other kin, and to express and practice their spiritual and religious beliefs.

The Challenge

Slightly more than half of children in kindergarten through 8th grade received some form of nonparental child care in 2001.[175] In 2001, one in four children in 4th through 8th grade regularly cared for themselves before or after school, as did 3% of children in kindergarten through 3rd grade.[176] Although some of these children are safe while unsupervised, others, especially younger and more immature children, are at risk.

More than half of children (53.3%) in 4th through 8th grade, and 43% of younger elementary school children participated in at least one organized activity outside of school hours, other than a structured before- or after- school program, in 2001.[177] Activities included music, dance, art, drama, sports, clubs, academic activities such as tutoring or math club, religious activities, and community services. Children in both age groups were much more likely to participate in sports than in any other activity.[178]

Poor children and minority children were much less likely to participate in activities than were other children. Only one in five poor children in the lower grades participated in an activity compared to nearly half of nonpoor children. The trend continued for children in the upper grades, where 28.7% of poor children participated in at least one activity compared to 59.3% of children above the poverty line.[179] White, non-Hispanic children were twice as likely to participate in an activity than were black, non-Hispanic, and Hispanic children in kindergarten through 3rd grade, and nearly twice as likely in 4th through 8th grade.[180]

Although it is not known how many children participate in afterschool programs nationwide, demand for these programs exceeds supply by two to one. "Virtually every survey of American youth suggests that they want to participate in well-designed, organized afterschool programs,"[181] and a recent Afterschool Alliance Poll found that nearly two-thirds of voters report difficulty in finding quality, affordable programs.[182]

Search Institute data suggest that adults could do more to promote the cultural awareness and understanding of youth. Although 77% of adults surveyed said that teaching children and youth respect for cultural values was important, only 36% said they were engaged in this work.[183] More research is needed about how we can promote the development of cultural identity and cultural sensitivity among children and youth.

Promising Solutions

Research suggests that adults can help increase young people's internal and external assets by [184]

1. **Providing opportunities for bonding**: increasing connections between children/ youth and healthy people and activities.
2. **Setting clear and consistent boundaries**: communicating expectations and providing for consequences that are consistently enforced.
3. **Teaching life skills**: ensuring that young people have the interpersonal and practical skills necessary to be successful.
4. **Providing caring support**: loving, respecting and valuing children and youth.
5. **Setting high expectations**: encouraging and assuming that children and youth will do well, and supporting them in their efforts.
6. **Providing opportunities for meaningful participation**: giving young people valued roles in their families, schools and communities.

High Quality Afterschool Programs

Children who regularly attend high-quality afterschool programs have better school conduct and better grades, better peer relations and emotional adjustment, more academic and enrichment opportunities, and lower incidences of drug-use, violence, and pregnancy.[185] Parents and teachers also report that students are more confident, especially about their learning ability, and more excited about school.[186]

Model program management practices for afterschool programs proposed by RAND researchers include:[187]

- Ensuring that programming is flexible,
- Establishing and maintaining a favorable emotional climate,
- Establishing clear goals and evaluating programs accordingly,
- Having a mix of younger and older children,
- Keeping total enrollment low,
- Maintaining a low child-to-staff ratio,
- Maintaining continuity and complementarity with regular day school,
- Paying adequate attention to safety and health,
- Providing a sufficient variety of activities,
- Providing adequate space,
- Providing age-appropriate activities and materials, and
- Providing enough quality materials.

More than nine in ten Americans surveyed thought that children need organized activities or a program to go to after school where they have learning opportunities.[188] Nearly nine in ten voters said they supported funding for quality afterschool programs in low-income neighborhoods as an important aspect of government programs like welfare reform.[189]

MODEL PRACTICE

LA's BEST (Better Educated Students for Tomorrow) is a comprehensive afterschool program available to students in kindergarten through 5th grade in 69 sites from the end of the school day until 6:00 P.M. at no cost to parents. Students receive homework assistance, take field trips, and participate in other educational and recreational activities. Evaluations have shown that higher levels of program participation led to better school attendance, resulting in higher academic achievement on standardized tests of reading, mathematics, and language arts. Limited-English proficiency students who participated in LA's BEST were more likely to be redesignated as English proficient than their nonparticipating peers.

UCLA Center for the Study of Evaluation. (2002, June). *A decade of results: The impact of the LA's BEST After School Enrichment Program and subsequent student achievement and performance*. Available from www.lasbest.org/learn/uclaeval.pdf.

OPPORTUNITIES FOR POSITIVE YOUTH DEVELOPMENT

The Need

Young people have complex developmental imperatives to explore, and require attention and resources to navigate these pathways successfully. The ingredients of healthy adolescent development include competence in academic, social, and vocational areas; positive self-identity; healthy relations to community, family and peers; positive values, integrity, moral commitment; and caring and compassion.[190]

Youth development is an ongoing process in which young people develop the skills and competencies needed to become contributing members of society. Positive youth development focuses on the strengths and potential of all young people and places an emphasis on providing supports and opportunities that promote development as opposed to identifying and fixing problems.[191]

Like younger children, adolescents benefit from participation in enrichment activities that develop their skills and talents and contribute to their communities. Teens who regularly take part in community-based youth development programs, including arts, sports, and community service, have better academic and social outcomes, as well as higher education and career aspirations, than other similar teens.[192]

Community and civic engagement benefits individuals and communities while increasing an adolescent's opportunities for success. Teens involved in community service are more likely to have a strong work ethic and to vote as adults.[193] Volunteering in adolescence is related to positive psychological, academic, and occupational outcomes.[194]

Spiritual growth and religion are valued by many youth. Adolescents who see themselves as religious have lower rates of drug abuse[195] and are less likely to engage in violent behaviors or to get in trouble at school.[196]

The Challenge

Participation in school athletics in 2000 decreased from 67%-70% in 8th grade to 54%-56% in 12th grade.[197] Although more than half (54%) of 8th grade youth participated in school music or other performing arts in 2000, only two of five (40%) 10th and 12th graders did so.[198] Around 30% of 8th, 10th, and 12th graders volunteered at least once a month in 2000.[199]

Based on national and multicity surveys, a estimated half to three-quarters of youth participated in formal youth development programs.[200] According to the National Center for Education Statistics, youth of color and youth living in urban areas have lower rates of participation in formal youth development activities.[201] Youth in families with lower incomes and those living in urban communities also had less access to such programs, according to the National Commission on Children.[202]

Despite increases in services and funding in recent years, funding streams and their respective services remain insufficient and fragmented. Furthermore, investments in adolescents that support their preparation for adulthood and participation in the decision making processes that affect them do not come close to the dollars spent on prevention and punishment.

Many youth value their religious and spiritual connections. When asked "How important is religion in your life?," 37% of 8th graders and 30% of 10th and 12th graders answered "very important."[203]

For all youth, discovering their personal identity is a journey. For some, this journey can be extremely challenging. Discovering what makes you unique may also mean identifying

ways in which you may not always fit in. Youth from minority racial, ethnic and religious backgrounds may face discrimination. Similarly, gay, lesbian, bisexual or transgendered youth may find the process of identity development more difficult when family members and other traditional supports are not available.[204]

Promising Solutions

Positive Youth Development Programs

Youth development frameworks are helping to define developmentally appropriate, youth-centered approaches that engage families, communities, and service providers in supporting youth. Programs that embrace a positive youth development approach foster caring relationships between young people and adults; ensure that young people feel safe; support young people in learning about the world; and provide opportunities for young people to be engaged in activities that are meaningful to them.[205]

Youth development is facilitated when youth have opportunities to feel physically and emotionally safe, when they have relationships with caring adults, acquire knowledge and information, and engage in activities that offer meaning, continuity, and variety.[206] Youth engagement strategies that purposefully strengthen skills and enhance responsibilities provide promising pathways to success.[207] On the other hand, programs and interventions that provide only isolated opportunities for youth involvement can lead to additional problems.[208]

Parents and other adults can protect adolescents while also helping them to meet their developmental needs by:

- Understanding the needs being met through the risk-taking behaviors,
- Supporting youth in taking risks that will meet those needs in positive and safe ways,
- Providing teens with a range of accessible activities that can meet their developmental needs,
- Balancing adolescents' desire for independence with clear rules and limits,
- Helping teens understand the facts about risks involved in various behaviors,
- Making sure youth have opportunities to practice making good decisions, and
- Modeling safe and healthy risk-taking by engaging in activities that are challenging but not harmful to self or others.[209]

Building Interdependent Living Skills

Youth development approaches can serve as guideposts for providing services and supports to help youth make successful transitions to adulthood. Many programs are effective in helping youth acquire independent living skills. These skills are increasingly referred to as "interdependent" living, in recognition of the essential role that relationships and mutual supports play in successful adult life.

Many of the focused efforts to help youth make the transitions to adulthood target youth at risk, including those living in out-of-home placements. For these youth, achieving optimal functioning means coping with life experiences that can chal-

MODEL PRACTICES

Youthbuild USA is a program model that combines building competence, confidence and connections. Through it, teens in 42 states and Washington, D.C., renovate abandoned buildings and help revitalize their communities. Of students, 60% remained involved for the full 11-month program, and 85% of these youth were placed in college or jobs. Youth Build USA. Available online at www.youthbuild.org.

The **Boys and Girls Clubs of America's Project Learn** includes five major components: homework help and tutoring, high-yield learning and leisure activities, parent involvement, collaboration with schools, and incentives. Project Learn participants ages 10 to 15 increased their overall grade point averages by 11% and showed improved school attendance and study skills.

Youth Build USA. See www.youthbuild.org.

lenge their intellectual, emotional, and physical development. It also means finding additional supports and resources to meet their needs.

Faith-Based Programs

Faith-based programs promote spiritual development in the context of a wide array of religious traditions. In Washington, DC, for example, about 95% of churches provide outreach services and nearly all churches have youth ministries.[210] An estimated 3,500 youth are engaged in these faith-based services through churches and faith-based nonprofit organizations each week.[211]

MODEL PRACTICE

The **Work Appreciation for Youth** (WAY) scholarship program, developed by Children's Village in Dobbs Ferry, New York provides boys who are 11 to 21 years old and living in residential care with paid mentors who work with them through a progression of responsibility and work. A 15 year study of 103 boys who had completed at least five years of the programs showed that 95% were in school, working, or had completed their GED.

Child Welfare League of America. (2001). Available from www.cwla.org/programs/r2p/cvarticlesway.htm

n one of her neigh-
ld police she believed
J. had left her four
hildren home alone in
shington Heights
g development on
nville, Florida's north
he young mother was
tly arrested on felony
s of child neglect. The
s were prepared to
their standard
dures, which would
neant calling in the
tment of Children and
es to remove the
en...
when the police
d that evening, two
mothers in the 200 unit
lly subsidized housing
pment turned
rd procedure on its
One neighbor was
y watching Crystal's
ildren in her own
nent. The others
nced the police officers
would care for the
en overnight—and that
ne from the complex
vouch for the children's
to the state authorities
ry next day. Commu-
sidents were able to
e that the children

ued on pg. 40)

Safety

Children's safety and security depend first and foremost on their parents' ability and willingness to protect them from exposure to violence and other harms. Protecting children in their homes, neighborhoods, and schools is also the shared responsibility of family members, neighbors, educators, public and private agencies, law enforcement, and community residents.

American children and youth face violence in many forms in their homes, neighborhoods, and schools. They may witness or be the targets of physical assaults, sexual abuse or harassment, or bullying by their peers. Our children are exposed to news reports and entertainment media depictions of violence beginning very early in their lives.

The continuum of physical violence against children ranges from bullying (repeated physical or psychological harassment, abuse, oppression, or intimidation), to serious physical assault. The continuum of sexual violence extends from sexual harassment, (including unwelcome sexual advances, requests for sexual favors, and other unwelcome verbal, nonverbal, or physical conduct of a sexual nature) to sexual assault.

All of these forms of violence can have varying short-term and long-lasting negative impacts on children's psychological, emotional, and intellectual development, perpetuating a cycle of violence that reduces the quality of life for all of us.

Strategies for protecting children and youth from various harms generally fall into four categories:

1. **Changing the Social Climate**: Create less tolerance for the harms and more support for action to change them. For example, change attitudes regarding the attractiveness of violence and the acceptance of violence in children's television programming or decrease tolerance for bullying within the school environment.
2. **Lessening Harms**: Lessen the harmfulness of people, things, and substances that hurt children. For example, decrease media violence or the prevalence of gangs within the community.
3. **Limiting Access**: Reduce children's access to people, things, and substances that harm them, and vice versa. For example, limit the child's television viewing time, limit the types of programs that can be viewed, possibly by installing a V-Chip, or keep guns out of the hands of youth without proper supervision.
4. **Reducing Children's Vulnerability**: Decrease children's vulnerability to harmful people, things, and substances. For example, discuss media violence with children, helping them to understand that in real life violence hurts people and that there are consequences for it, or teach children to report abuse when it occurs.

We must employ current strategies and develop and implement new ones in all four categories to more effectively protect our children in the areas of greatest concern.

Children and youth also need protection from harms other than violence. Their basic needs may be neglected by parents or caregivers or, they may experience discrimination due to race, gender, culture, or religion. Accidental injuries, such as falls and drowning, and those caused by car accidents and firearms, are threats for every child. Lastly, exposure to environmental toxins, such as lead and second-hand smoke, can cause physical and neurological damage to children.

BEST COPY AVAILABLE

PROTECTION FROM FAMILY VIOLENCE

The Need

Children and youth who are at risk by witnessing domestic violence or through their physical, sexual, and emotional abuse[213] by their parents and caregivers need protection. Their parents need support to be protective and nurturing.

Children and youth who experience abuse or neglect are generally more likely to have mental health and behavioral problems than those who are not maltreated. Early abuse or neglect can have a negative impact on brain development,[214] and chronic trauma and associated stress can lead to hyperactivity, anxiety, impulsivity, and sleep disorders.[215] As they get older, abused or neglected children are more likely to perform poorly in school, to commit crimes, to experience emotional or sexual problems, and to abuse alcohol or other drugs.[216]

Young children who are exposed to domestic violence are more likely to experience eating and sleeping difficulties, moods swings, depression, and delays in language or social development. Older children witnessing domestic violence may be anxious, depressed, fearful, or socially isolated, and may exhibit difficulties in school performance.[217] Youth who have witnessed family violence are more likely to attempt suicide, abuse drugs and alcohol, drop out of school, run away from home, engage in prostitution, and commit sexual assaults.[218]

Girls who have grown up with family violence are more likely to become domestic violence victims.[219, 220] Boys exposed to abuse of women are more likely to become perpetrators of domestic violence themselves. In a Baltimore program for batterers, 75% of the men reported witnessing their fathers beat their mothers, and 50% reported having been abused as children.[221]

The Challenge

Child protective services agencies nationwide confirmed an estimated 879,000 children as victims of abuse and neglect in 2000, a rate of 12.2 per 1,000 children.[222, 223] Among the confirmed cases in 2000, 62.8% of child victims were neglected, 19.3% were physically abused, 10.1% were sexually abused, 7.7% were emotionally maltreated, and 16.6% suffered from other forms of neglect or abuse, such as abandonment and congenital drug abuse. In that same year, 1200 children died due to abuse and neglect.[224] Maltreatment deaths were more often associated with neglect (34.9%) than with any other type of abuse.[225]

In some families, child abuse may result from a parent's lack of knowledge about child development along with the impact of the circumstances of his or her own childhood. In others, the stress of poverty, combined with a parent's substance abuse problem, may contribute to child neglect. Many combinations of parent, child, family, and community characteristics can increase the risk of child maltreatment,[226] just as many combinations of protective factors can decrease the risk.

Every year, 3 to 10 million children witness domestic violence in their own homes,[227] including violence against their parents, siblings, or elders. Child abuse occurs in an estimated 30% to 75% of families in which domestic violence or partner abuse occurs.[228] Domestic violence is also a precursor to child maltreatment fatalities.[229]

Promising Solutions

Community-Based Efforts to Prevent Child Abuse and Neglect

Building on families' strengths and protective factors and minimizing the influence of risk factors in their lives can help prevent child abuse and neglect. The quality of neighborhoods can

(continued from p. 39)

would be well cared for whil
their mother was in jail.

Crystal's neighbors,
trained members of the
Community Partnership for
Protecting Children, now
wield greater responsibility
for the health and safety of
their neighbors' children.
Their presence means
government is no longer th
first and final line of
protection against child
abuse and neglect. And
stronger communities are
healthier communities.[217]

Thanks to the Communit
Partnership for Protecting
Children in Jacksonville,
Florida, neighbors stepped
up to help protect Crystal's
children. The children's
forced removal from their
home was avoided because
strengthened and networke
community took charge. Th
support did not happen
overnight, and without
considerable effort and
investment on the part of t
parents, community leader
agency heads, and staff.

BEST COPY AVAILABLE

MODEL PRACTICE

Community Partnerships for Protecting Children, funded by the Edna McConnell Clark Foundation, operates in four jurisdictions (Jacksonville, Florida; St. Louis, Missouri; Cedar Rapids, Iowa; and Louisville, Kentucky) across the country. The initiative's goal is to collaboratively make improvements intended to increase child safety, improve parents' access to the supports they need to care for their children, increase the effectiveness of local agencies, and expand the capacity of community residents to seek out and offer support to one another. Preliminary findings from the project's evaluation show good progress on the implementation of the initiative's key components, including an increased sense of unity and pride within the neighborhoods; strengthened local institutions; improved communication and coordination across agencies; and a widening of the range of services, supports, and interventions.

See http://www.emcf.org/programs/children/index.htm

either encourage or impede parents in meeting their responsibilities toward their children.[250] Neighborhoods with a sense of community and mutual reciprocity can support parents in nurturing their children, and reduce the risk of child abuse and neglect.[251]

Communities and service providers can assist parents and caregivers by increasing their opportunities to learn about effective parenting strategies, providing for quality child care, and ensuring their access to supportive services in times of stress or crisis.

As noted in Chapter Three, nurse home visiting brings community resources to at-risk families in their homes. High-risk families appear to benefit most, although studies show benefits for families at both low and high risk of child abuse and neglect. Nurse home visiting has demonstrated substantial positive results, particularly when provided to single teen parents living in high-poverty communities.[252] These services can dramatically improve the safety of home environments, thus lowering the rate of reported child abuse and neglect and reducing the number of children's hospital visits in the first four years of life.[253]

Many communities have implemented a variety of initiatives that enhance their ability to protect children, including co-location of traditional service providers in community-based sites, encouraging participation of diverse community organizations in protecting children, and increasing involvement of neighbors and other informal/natural helpers in supporting families.

Implementing prevention programs that provide home visiting or parent education services to every parent or family having a first baby costs a tiny fraction of what it would cost to respond to abuse or neglect of those children.[254]

Respite and Crisis Care

Respite care and crisis care services provide temporary relief in the form of child care for caregivers of children at risk of abuse or neglect, as well as those with special needs. Such services are highly successful in preventing or reducing abuse and neglect in families facing emergencies and/or the continuing demands of caring for a family member with a disability. Respite and crisis care can enhance parents' capacities to cope with stress and enable them to continue supporting one another and nurturing their children, thus avoiding the need for child protective services intervention.[255]

- An evaluation of families of children at risk of abuse or neglect who used the San Francisco Bay Area's Respite Care Program found that 90% reported reduced stress, improved family relationships, improved positive attitudes toward the child, and other significant benefits that would help reduce their risk.[256]
- In 1999, the Minnesota Department of Human Service, Family and Children's Services Division, reported that crisis nursery clients in programs serving 18 counties showed a 67% reduction in child protection involvement after using these services.[257]
- A study of Vermont's 10-year-old respite care program for families with children or adolescents with serious emotional disturbance found that participating families experience fewer out-of-home placements than nonusers, and were optimistic about their future capabilities to care for their children.[258]

Treatment for Substance-Abusing Parents

Evidence from various national studies suggests that between 40% and 80% of all child abuse and neglect cases involve parental misuse of alcohol and other drugs (AOD).[239] Timely assessment and appropriate services and supports for families with substance abuse problems can help to prevent abuse and neglect and the unnecessary separation of children from their caregivers. Given the prevalence of joint substance abuse and child maltreatment issues, the need for routine substance abuse screening in every CPS assessment–and referral where indicated–is evident. Effective early interventions for parental substance abuse can avoid the tremendous costs associated with chronic substance abuse, child abuse and neglect, and alternate care for children.

SAMHSA's National Treatment Improvement Evaluation Study and other research have demonstrated that effective, comprehensive services–including training in life skills, job readiness, and parenting–provided over 6 to 18 months to substance-abusing mothers resulted in the women improving their parenting skills, reducing or stopping their drug usage, gaining employment, having no further involvement with the criminal justice system, and having their children continue or return to living safely with them.[240]

MODEL PRACTICE

In California, a Sacramento County Department of Health and Human Services initiative makes alcohol and other drug (AOD) assessment and intervention the responsibility of every child welfare worker. AOD and child welfare staff receive necessary training, and the percentage of children living with parents who graduate from the AOD program has increased by nearly half.

Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy*. Washington, DC: CWLA Press.

Protecting Children from Witnessing Violence

The best way to protect children from witnessing violence is to reduce the level of violence in American homes, neighborhoods, and schools. Because exposure to violence often stems from multiple sources and has a cumulative impact, strategies to reduce exposure to violence must take an interdisciplinary approach, working with domestic violence prevention and intervention experts, juvenile justice, child protective services, schools, community leaders, and law enforcement.

Children Who See Too Much: Lessons from the Child Witness to Violence Project, offers six steps, consistent with the Framework goals, that would make a difference in creating a safer world for children:[241]

1. Children must have steady, predictable, and loving relationships from birth.
2. Children and families must have access to a network of skillful helpers to facilitate healing from the effects of exposure to violence.
3. Adults must assume the responsibility of setting standards of respect, civility, and nonviolence for children.
4. To reduce violence in communities and homes, we must reduce poverty in the United States.
5. We must create a social climate that makes violence against women and children unacceptable.
6. Each of us can be an advocate for children's safety and well-being.

PROTECTION FROM SCHOOL AND COMMUNITY VIOLENCE

The Need

All parents want their children to be and to feel as safe as possible. Yet, in their neighborhoods, schools, and communities, children and youth face physical, emotional, and sexual victimiza-

MODEL PRACTICE

The **Strengthening Multi-Ethnic Families and Communities Program** is a unique integration of various prevention/ intervention strategies geared toward reducing violence against self, the family, and the community. The program targets ethnic and culturally diverse parents of children ages 3 to 18 who are interested in raising children with a commitment to leading a violence-free, healthy lifestyle. The program's goal is to reduce drug/alcohol use, teen suicide, juvenile delinquency, gang involvement, child abuse, and domestic violence. Evaluation studies show that the program helps with childrearing challenges, encourages family bonding, promotes pride in cultural heritage, supports community bonding, and reduces life-threatening risks for children.

See http://www.casatweb.ed.unr.edu/cgibin/WebObjects/Step6.woa/1/wo/Qa9bA2OknqtgZ87WOjBCWg/0.7.20.0.

tion by adults outside of their families as well as by other juveniles. Teens currently experience more than twice the rate of violent crimes as do adults.[242] More than four out of every five violent criminal offenses against children and youth in 1996 were perpetrated by people other than their parents and caregivers.[243]

This violence negatively impacts the quality of life and the development of the children who experience it, and may increase the likelihood that they will commit acts of violence or be revictimized in the future.

Bullying, teasing, and sexual harassment are a common part of daily school life for children and youth in America. Victims often suffer humiliation, insecurity, and a loss of self-esteem, and may develop a fear of going to school.[244] Those who bully others are more likely to engage in other forms of antisocial behavior such as vandalism, shoplifting, skipping and dropping out of school, fighting, and the use of drugs and alcohol.[245] Both children who bully and those who are bullied need guidance and support from parents and teachers.

Many poor children live in neighborhoods where violence in commonplace. For example, in 1999 in New Haven, CT, 39% of 6th, 8th, and 10th grade students had seen someone shot at in the preceding year.[246] In Richmond, VA, 25% of children reported having seen someone killed.[247]

Parents struggle to teach their children how to navigate in an unsafe world without making them overly fearful. Schools, law enforcement agencies, and others in communities contribute in many ways to keeping children safe.

The Challenge

Bullying and Harassment at School

In a 1999 survey, 1 in 20 high school students stated that they had missed one or more days of school during the previous month because they felt too unsafe to go to school.[248] Of 8th- through 11th-grade students, 18% are afraid "some or most of the time" that they will be sexually harassed or hurt at school, while 46% said that they are never afraid at school.[249]

According to a 2001 survey of children ages 8 to 15, Bullying and teasing topped the list of children's school troubles, ranking higher than pressure to use alcohol and drugs, or to have sex.[250] The children surveyed ranked violence as the third biggest problem at school.[251] In a recent national survey, three in four 8th through 11th grade public school students–both girls and boys–reported that they had experienced while in school nonphysical sexual harassment, such as sexual taunting, rumors, graffiti, jokes, or gestures, and 58% reported experiencing physical sexual harassment, such as touching, pinching, pulling off or down their clothing in a sexual way, or forcing them to do something sexual other than kissing.[252]

Violent Crimes against Children and Youth

Around four in five physical assaults (82%) and sexual assaults (77%) on children and youth are perpetrated by relatives (other than parents), adult and juvenile acquaintances, and to a far lesser extent, strangers.[253]

Violent crimes against teens, including homicide, rape, robbery, and both simple and aggravated assault, have dropped dramatically since 1993, as have violent crimes against all individuals.[254] The numbers, however, remain staggering.

- According to the National Crime Victimization Survey, an estimated 51,087 sex offenses were committed against juveniles ages 12 through 17 in 2000, with an estimated 71% of these known to police.[255]
- Data in the FBI's National Incident-Based Reporting System for 1999 suggest that the number of sex offense victims ages birth through 11 known to police was roughly the same as that for 12- to 17-year-olds. In 1999, 35,879 children and youth received emergency room treatment for injuries due to sexual assault.[256] Girls were treated for such injuries nearly four times as often as boys.
- One in ten adolescent girls reported being physically abused by her dating partner in a 2001 study.[257] One in ten adolescent girls also reported being sexually abused by a date, often in the context of physical abuse.[258]

Violence by Youth

Between 1994 and 1999,the juvenile crime rate decreased dramatically, with a 68% decline in homicides committed by youth.[259] The 1999 Juvenile Violent Crime Index arrest rate was at its lowest level since 1988, and 36% below its peak in 1994.[260]

Despite these trends, youth-on-youth violence in homes, neighborhoods, and schools remains a serious threat to child and youth safety. In 1999, 36% of high school students completing the national Youth Risk Behavior Surveillance System (YRBSS) questionnaire said they had engaged in a physical fight during the previous year, 17% reported carrying some sort of weapon at least once during the previous month, and 1 in 20 reported carrying a gun during the previous month.[261]

Promising Solutions

Bullying Prevention

Bullying behavior is best addressed in schools by programs that set clear limits, teach new skills, and protect victims.

Child Sexual Abuse Prevention

Parents, relatives, teachers, elected officials, and others can employ the following strategies to lessen the danger of child sexual abuse:

- Support talking openly about child sexual abuse.
- Oppose the sexualization of children in advertising and other media.
- Ensure that child sex offenders receive appropriate consequences and treatment.
- Encourage potential offenders to self-identify and receive treatment.
- Limit child sex offender's access to children by screening paid and volunteer staff who work in positions where they have access to children.

MODEL PRACTICE

The **Olweus Bullying Prevention Program,** developed and evaluated in Bergen, Norway, and now being implemented in numerous communities in the United States, is designed to reduce bullying among elementary, middle, and junior high school children. It involves school staff, students, and parents in efforts to raise awareness about bullying, improve peer relations, intervene to stop intimidation, develop clear rules against bullying behavior, and support and protect victims. Intervention occurs on the school, classroom, and individual level.

Research showed bullying decreased by 50% or more over the two years of the program. Behavioral changes were more pronounced the longer the program was in effect. School climate improved, and the rate of antisocial behavior, such as theft, vandalism and truancy, also declined during the two-year period.

Olweus. (2001). Blueprints for violence prevention, 1999. In N. Ericson (Ed.), *Addressing the problem of juvenile bullying* (OJJDP Fact Sheet #27).

- Provide supervision for children, keeping them visible and safer from harm.
- Nurture children to meet their needs for love, attention, support, and understanding so that they will not be as vulnerable to victimizers offering attention.
- Teach and model attitudes, knowledge, and skills that assist children to be aware of dangers, to resist them, and to seek help when at risk of harm.

Although evaluations of child sexual abuse prevention programs for school-age children have demonstrated their success in teaching basic concepts and skills related to personal safety, there is no evidence that knowledge of safety skills results in behavior that reduces the likelihood of sexual abuse.[262] These programs, however, have resulted in secondary prevention, since children who had been abused were more likely to report it following the programs.[263]

Innovative approaches, such as STOP IT NOW!, focus on creating a social climate where sexual abuse is not tolerated, and where potential sexual abusers are confronted on their behavior and supported in getting treatment.

Afterschool Programs

School-age children who are unsupervised during afterschool hours are more likely to use alcohol, drugs, and tobacco; engage in criminal and other high-risk behaviors; receive poor grades; and drop out of school.[264] On school days, juvenile crime triples between 3:00 P.M. and 8:00 P.M.; these hours are also the peak time for crimes against children and youth.[265] Communities can protect children and reduce juvenile crime through the provision of quality afterschool programs, as described in Chapter Five.

School-Based Youth Violence Prevention

Too many teens find themselves in high-risk, violent situations. A combination of individual, family, school, and neighborhood factors puts young people at risk as victims or perpetrators of violent behavior.[266] To prevent youth violence, we must intervene with a combination of efforts that strengthen children and families at risk while also improving neighborhoods and schools.[267]

In 1997, the *Journal of School Health* identified nine essential components of school-based violence protection.[268]

1. A comprehensive, multifaceted approach that includes family, peer, media, and community components allows for the reinforcement of new skills at home, at school, and in the community. Such interventions should be both universal (i.e., classroom instruction) and targeted (i.e., mediation programs). Increased parental involvement is crucial.

MODEL PRACTICE

STOP IT NOW! is a nonprofit organization founded on the belief and experience that we as individuals and as a society can challenge and change the way we act.

STOP IT NOW!'s mission is to call on all abusers and potential abusers to stop and seek help, to educate adults about the ways to stop sexual abuse, and to increase public awareness of the trauma of child sexual abuse.

STOP IT NOW! programs go beyond treating the symptoms of child sexual abuse to address the root causes through four tools: (1) develop awareness in potential abusers and encourage them to seek help; (2) challenge abusers to stop the abuse immediately and seek treatment through a helpline or on the Internet; (3) work with families, peers, and friends on how to confront abusers; and (4) join with others to build a social climate that says "We will no longer tolerate the sexual abuse of children."

See http://www.stopitnow.com.

MODEL PRACTICE

Just one year after the 1995 opening of the **Goodnow Police Athletic League** (PAL), an afterschool program in Northeast Baltimore, the Baltimore Police Department saw a 44% drop in the number of children and youth who become crime victims in the area, and a 10% decrease in the number of juvenile arrests.

Baltimore Police Department Division of Planning and Research. (1998). *Juvenile victimization comparison for Goodnow PAL Center Area*. Baltimore: Author.

MODEL PRACTICE

In Mineola, New York, the **Family and Children's Association** developed a five-part training series for elementary school cafeteria aides and playground monitors (most of whom were paraprofessionals) to reduce school-based aggression and violence. The provision of information on child development, conflict resolution, positive discipline, and behavior management techniques helped the aides to enhance student safety, reduce negative interactions between aides and children, and help children manage their own behavior.

2. Programs that begin in the primary grades (1st grade if possible) and are reinforced across grade levels.
3. Interventions that are developmentally tailored.
4. Program content that promotes personal and social competencies, specifically information about the negative consequences of violence including: anger management, social perspective taking, decisionmaking, social problem-solving, peer negotiation, and conflict management.
5. Interactive techniques, such as group work, cooperative learning, discussions, and role plays or behavioral rehearsal that facilitate the development of personal and social skills.
6. Ethnic identity/culturally sensitive material that is matched with the characteristics of the target population.
7. Staff development and teacher training that ensures a program will be implemented as intended by the program developers. Interactive techniques in particular require training.
8. Activities that foster norms against violence, aggression, and bullying.
9. Activities that promote a positive school climate or culture, including effective classroom management strategies promoting good discipline.

Law Enforcement Strategies to Prevent Youth Violence

Law enforcement has an essential role to play in identifying youth at risk. Programs and approaches that take advantage of this position and provide a clear mechanism for linking at-risk youth to services in the community show great promise for preventing delinquency.

PROTECTION FROM MEDIA VIOLENCE AND INTERNET VICTIMIZATION

The Need

Television, movies, video games, and the Internet are wonderful sources of information, education, and entertainment for children and youth. They can also be damaging and dangerous. Children need protection from media violence and from Internet victimization.

Violence is pervasive in American entertainment media, including television, movies, and video games. Real violence is featured 24 hours a day on news programs, and fantasy violence permeates television programs, cartoons, and games.

Six major American professional societies[269] issued a joint statement on the impact of entertainment violence on children in 2000,

MODEL PRACTICE

The **Resolving Conflict Creatively Program** (RCCP) is a comprehensive research-based program for kindergarten through grade 12 that promotes social and emotional learning. The program seeks to prevent violence and create peace and caring in learning communities. The model assists school staff, families, parents and the community in helping children learn conflict resolution skills and "promotes intercultural understanding."

Model components include: professional development for teachers; classroom instruction; training for administrators, parents, and support staff; training of the trainers; and high school student leadership training and youth development.

An intensive study of the effects of the program found that: 65% of teachers who used the curriculum reported less physical violence in the class; 92% of students felt better about themselves; 90% of parents reported an increase in their communication and problem-solving skills; suspension rates decreased significantly while non-RCCP middle school rates increased during the same period; and the dropout rate at the RCCP high school decreased significantly while non-RCCP school rates increased during the same period.

See www.esrnational.org or contact Jennifer Selfridge, RCCP Program Director, 23 Garden St., Cambridge, MA 02131.

MODEL PRACTICE

The **Strategic Home Intervention and Early Leadership Development** (SHIELD) Program developed by the City of Westminister Police Department in Orange County, California, uses contacts that law enforcement officers make in the normal course of their duties to identify at-risk youth and connect them with community resources.

By improving coordination among law enforcement, social services, community service providers, and the school system, SHIELD facilitates early identification and treatment of at-risk youth who might otherwise be overlooked. The identification and referral activities are central elements of SHIELD and show promise for the mobilization of community resources to assist youth at risk.

Wyrick, P. A. (2000, November). *Law enforcement referral of at-risk youth: The SHIELD program. OJJDP juvenile justice bulletin.* Washington, DC: U.S. Department of Justice.

asserting that over 1,000 studies by leading figures within medical and public health organizations show a strong connection between media violence and aggressive behavior in some children.[270] A 2002 study suggests that extensive TV viewing among adolescents and young adults is associated with subsequent aggressive acts.[271]

The American Academy of Child and Adolescent Psychiatry reports that children become almost immune to the horror of televised violence, and that some children's viewing of violence on television is associated with their acceptance of violence as the means to solve problems, and their imitation of the violence they observe on television.[272]

Many agree with David Grossman, who asserts in *The Psychological Cost of Learning to Kill in War and Society*, "What we know, and it's been proven beyond dispute, is that television is a greater factor in this increased degree of violence in our society than all other factors combined."[273] Yet, on average, children watch approximately three to four hours of television per day.[274]

Children and youth who use the Internet may have unrestricted access to online pornography and are subject to harassment, threats, and approaches of both a sexual and nonsexual nature.

The Challenge

Media Violence

The average child in America witnesses more than 8,000 murders and 100,000 other violent acts on television by the time he or she leaves elementary school.[275] Prime time television contains about five violent acts per hour compared to an average of 26 violent acts per hour during typical Saturday morning children's TV programming.[276]

Many video games often include gory scenes that are becoming increasingly realistic as technology evolves. These games are extremely inappropriate for young children. The industry has developed its own ratings for the videos, but labeling a game as "mature" may only increase children's interest in it.

Internet Victimization

One out of four youth ages 10 to 17 who used the Internet regularly was exposed to unwanted pornography last year. Nearly one out of five encountered unwanted sexual solicitations and approaches. In 15% of such incidents, the solicitor attempted to contact the youth in person, by phone, or by mail; such incidents are termed "aggressive solicitations." Fifty percent of the solicitations were made by juveniles to other youth.[277]

Six percent of youth were subjected to harassment of a nonsexual sort that included threats of physical harm or postings of defamatory or embarrassing information. Only 10% of solicitations were reported to police, internet service providers, or other authorities.[278]

Promising Solutions

Reducing Media-Related Aggression

Two approaches have shown promise in reducing media-related aggression by children and youth. One common sense measure is to reduce children's exposure to violent media by not letting them watch violent shows. The other is to change children's attitudes toward media violence by discussing violent shows, helping them to understand that in real life violence has consequences.[279]

The V-Chip, a protective device that works with cable boxes, television, and VCRs, allows parents to protect their children from television violence. Parents have the ability to use

a rating system that identifies programs of mature nature and to deny access to programs and movies that are inappropriate for children to watch. Parents can then feel safe that when their children are watching TV unsupervised, they are not being exposed to violence on television.[280]

Violence in the media can become an educational tool and a source of adult-youth dialogue when parents, teachers, and other adults help young people understand how the images they are seeing are constructed, sold, and glorified. Increasing a child's media literacy (his or her understanding of how the media works) holds promise for mitigating the adverse effects of negative images in the media and empowers young people to use media as a learning resource.

The American Psychological Association and the American Academy of Pediatrics suggest that parents:[281]

- Try to keep their children from seeing too much violence in the media;
- Limit television viewing time to 1 to 2 hours a day;
- Be aware of the shows their children watch and the videos they play;
- Talk to their children about the shows, movies, and video games;
- Help their children understand how in real life there would be consequences for violent behaviors; and
- Discuss with their children how to resolve conflicts without violence.

Preventing Internet Victimization

A three-pronged strategy to improve youth safety online includes education for children and parents, better blocking and filtering software, and aggressive prosecution of internet offenders. The National Center for Missing and Exploited Children (NCMEC) advises parents to pay attention to, and supervise, younger children's online activities, and to talk to their children about those activities. It further recommends keeping track of files that children download to their computers, sharing internet accounts with children to oversee their e-mail, and joining children when they are in private chat areas.[282] Some software can prevent children from revealing personal information online, such as their name and address. Filtering and blocking software can enable parents to limit children's access to those websites, chat rooms, and newsgroups rated appropriate for minors.

MODEL PRACTICE

The National Center for Missing and Exploited Childre developed its ***NetSmartz*** website (http://www.netsm to help children have fun as they learn to navigate th Internet more safely. The site includes 3-D interactive for children and teens. It also includes information an resources for parents and educators, such as safety tip discussion questions, and lesson plans.

PROTECTION FROM DISCRIMINATION

The Need

Every day in America, children and youth are adversely affected by discriminatory acts and practices. Discrimination follows prejudicial thinking regarding a group seen as "different," or "lesser than" due to race, religion, gender, social class, or sexual orientation.

Discriminatory behavior occurs along a continuum, ranging from negative speech to discriminatory practices, property damage, physical assault, and murder.[283] Discrimination can have a devastating impact on a child's self-esteem, emotional well-being, and chances for success.

Discrimination in a family, school, or community is often informally "sanctioned" or "allowed" to exist. We owe it to our children and youth to speak up against discrimination in all its forms and to advocate for social justice.

The Challenge

In a 2002 study, 43% of children ages 8 to 11, and 67% of children ages 12 to 15 stated that kids at their schools "are treated badly because they are different"; nearly the same percentages said that discrimination was "a big problem for people their age in school."[284]

Hate Crimes Perpetrated by Youth

In 1999, nearly two-thirds of the 7,876 hate crimes reported in the United States were committed by teenagers or young adults.[285] These crimes were motivated by racial, religious, and ethnic biases as well as by prejudice due to sexual orientation and disability.[286]

Racial Injustice

Racial injustice is seen in the systems that serve children and youth when they are in trouble or when they cause trouble. Minority children are overrepresented in the child welfare and mental health systems, but their overrepresentation has been best documented in the juvenile justice system. Youth of color are treated more harshly than white youth for the same crimes at every critical decision point in the justice system: detention, formal processing in juvenile court, transfer to adult criminal court, disposition (sentencing), incarceration in juvenile facilities, and incarceration in adult facilities.[287]

African American youth adjudicated for drug offenses with no prior admissions were committed to state institutions 48 times as often as white youth adjudicated for drug offenses with no prior admissions. Similarly, the mean length of stay in state institutions for Latino youth adjudicated for violent offenses was 150 days longer, and for African American youth 90 days longer than for white youth adjudicated for the same offenses.[288]

Discrimination Against Gay, Bisexual, and Transgender Youth

For the more than 2 million young people in the United States who are lesbian, gay, bisexual, or transgender, discrimination comes in the form of persistent verbal abuse, harassment, physical violence, and sexual abuse from peers, family members, teachers, and administrators. Although the precise incidence of this discrimination is unknown, studies show that it is widespread. For example, one-third of 11th-grade students who responded to a 1999 CBS poll said that they knew of incidents of harassment of gay or lesbian students, and 28% admitted to making antigay remarks themselves. The average high school student in the Des Moines, Iowa, public schools hears an antigay comment every seven minutes and teachers intervened only 3% of the time.[289]

Verbal discrimination often escalates into physical violence and can have destructive consequences on a child's overall well-being, mental health, and academic performance. As a result, many gay youth respond with truancy, dropping out of school, or running away.[290] A study in the *American Journal of Public Health* found that teenagers with same-sex attractions, and those in gay and lesbian relationships, are twice as likely as their heterosexual counterparts to attempt suicide.[291]

Often school and laws do not respond to discrimination based on sexual orientation, viewing such actions as "pranks," or "childish teasing," or not seeing it at all. Only eight states

and the District of Columbia legally protect students on the basis of sexual orientation and/or gender identity; those jurisdictions account for only 11.9 million students–25% of the country's school children.[292]

Promising Solutions

Protecting Children and Youth from Discrimination

We must protect children from the influences, social norms, and actions of adults who perpetuate or "teach" discriminatory actions and practices against others whom they see as "different" and often inferior. This involves working to prevent children from making discrimination and bias part of their values systems, while protecting them from being the targets of discrimination by their peers and by adults.

Ongoing communication with minority children can help to build their self-esteem, to educate them about the realities of discrimination, and to assist them in dealing with prejudice. Remignanti notes that "When parents of minority group children talk to their children about racial issues and present a clear and positive view of their racial group, children from an early age develop healthy self-concepts and self-esteem. Children of color can be aware of prejudice and understand racial stereotypes, but at the same time develop a confident and well-integrated view of themselves. This process is vastly improved when parents discuss race issues in an open and balanced way."[293]

Building healthy and viable communities has everything to do with decreasing discriminatory practices and categorical assumptions about individuals and groups of people. Preventing discrimination begins at home. All parents and caregivers need to ensure that they model unbiased attitudes for their children and that they teach them skills for confronting discrimination.

Although the Southern Poverty Leadership Center's "Ten Ways to Fight Hate"[294] focuses on community responses to hate crimes, the methods also apply to fighting all types of discriminatory behaviors.

1. **Act:** Do something. In the face of hatred, apathy will be interpreted as acceptance–by the haters, the public and, worse, the victim. Decency must be exercised, too. If it isn't, hate invariably persists.
2. **Unite:** Call a friend or coworker. Organize a group of allies from churches, schools, clubs, and other civic sources. Create a diverse coalition. Include children, police, and the media. Gather ideas from everyone, and get everyone involved.
3. **Support the Victims:** Hate-crime victims are especially vulnerable, fearful, and alone. Let them know you care. Surround them with people they feel comfortable with. If you're a victim, report every incident and ask for help.
4. **Do Your Homework:** Determine if a hate group is involved, and research its symbols and agenda. Seek advice from antihate organizations. Accurate information can then be spread to the community.
5. **Create an Alternative:** Do NOT attend a hate rally. Find another outlet for anger and frustration and people's desire to do something. Hold a unity rally or parade. Find a news hook, like a "hate-free zone."
6. **Speak Up:** You, too, have First Amendment rights. Hate must be exposed and denounced. Buy an ad. Help news organizations achieve balance and depth. Do not debate hate mongers in conflict-driven talk shows.

MODEL PRACTICE

Publicolor was established in 1996 in New York City with the purpose of engaging young people from diverse backgrounds in transforming their schools into warm, clean, and colorful places, while easing racial tensions within their communities.

Students, teachers, parents, and community members of different cultures are asked to meet on Saturdays to paint schools. Members are asked to agree on colors that represent the diversity that exists in schools. Teenagers learn good work habits, leadership skills, painting skills, and collaboration among diverse groups.

After the school is completed, group members paint other structures within their community such as homeless shelters and community centers. A "Toolbox Program," including tutoring, advisory workshops, mentoring, and practical workshops, is also offered to young students.

Independent evaluations found that the program has made a significant difference within schools. Not only do members and schoolmates feel an improved sense of pride and ownership for their school, they also have a stronger sense of cultural identity.

See www.publicolor.org.

MODEL PRACTICE

Peace Games was created to teach children the importance of respect for differences, personal responsibility, and cooperation. Through role playing, games, community service projects, violence prevention activities, and an annual Peace Games festival, college volunteers work with children who have just entered kindergarten to increase communication and cooperation cross-culturally and reduce violence and bigotry. Results from the nine elementary and middle schools in the Boston, Massachusetts area that Peace Games has partnered with show that 85% of the students reported that Peace Games taught them how to resolve conflicts without fighting, and 95% of teachers felt that their students learned how to resolve conflicts better.

See http://www.empowermentzone.com/promprac.txt.

7. **Lobby Leaders:** Persuade politicians, business, and community leaders to take a stand against hate. Early action creates a positive reputation for the community, while unanswered hate will eventually be bad for business.
8. **Look Long Range:** Create a "bias response" team. Hold annual events, such as a parade or culture fair, to celebrate your community's diversity and harmony. Build something the community needs. Create a website.
9. **Teach Tolerance:** Bias is learned early, usually at home. But children from different cultures can be influenced by school programs and curricula. Sponsor an "I have a dream" contest. Target youths who may be tempted by skinheads or other hate groups.
10. **Dig Deeper:** Look into issues that divide us: economic inequality, immigration, homosexuality. Work against discrimination in housing, employment, and education. Look inside yourself for prejudices and stereotypes.

Safety, antidiscrimination, bullying prevention, cultural awareness, and other school programs must take extra steps to include awareness and prevention of the circumstances confronting gay, lesbian, bisexual, and transgender adolescents.

Practicing and valuing diversity builds a firm foundation for equality, but it is not enough. As Blackwell, Kwoh and Pastor assert, "Diversity at the top of the social ladder, in the President's cabinet, for example, does not necessarily spell equality and justice at the bottom... those at the bottom are most often forgotten."[295]

We must advocate for racial and social justice in all aspects of society if all children and youth are to be safe, healthy, and thriving. We must do it for them and for all of us since, "the very future of the American economy and society will be based on how well opportunities are opened to all the nation's people."[296]

PROTECTION FROM ACCIDENTAL INJURY AND DEATH

The Need

Each year thousands of children and youth die and hundreds of thousands are seriously injured due to motor-vehicle, home, and recreational accidents.[297] The leading cause of death for children age 5 to 14 is unintentional injuries. Most of these accidents are preventable.

The Challenge

Motor Vehicle-Related Accidents

Motor vehicle-related accidents are the leading cause of death among youth in the United States. In 1999, more than 4,090 children under age 18 were fatally injured in a motor vehicle accident. More than two-thirds of these children were unrestrained or not restrained properly. In the same year, another 543,058 youth drivers, passengers, and pedestrians were injured in motor vehicle accidents.[298]

Teenagers are more likely than older drivers to speed, run red lights, make illegal turns, ride with an intoxicated driver, and drive after using alcohol or drugs.[299] The crash risk is particularly high during the first years that teenagers are eligible to drive.[300]

The Youth Risk Behavior Survey, a 1999 national school-based survey of high school students, found that 16.4% of students never or rarely wore a seat belt when riding in a car driven by someone else, and 13.1% reported that in the past 30 days they had driven vehicles one or more times when they had been drinking alcohol.[301]

In 2001, 367 children were injured and 92 children died as a result of being left u nattended in or around motor vehicles. These were nontraffic incidents on public or private property.[302]

Home and Recreational Accidents

Drowning was the second leading cause of unintentional injury deaths among children, with 1,127 children in the United States drowning in 1999.[303]

In 2000, 368,000 home fires occurred in the United States, down one-third from 1980.[304] Home fires resulted in 615 child deaths in 1999, and 158,447 injuries in 2000.[305] Children under the age of five are particularly vulnerable to injury and death due to residential fires.[306]

In 2000, 220 children under age 18 died in bicycle-related accidents.[307] That same year, an estimated 427,082 children and adolescents sustained a bicycle-related injury that required emergency room care.[308] An estimated 140,000 children are treated each year in emergency rooms for head injuries sustained while bicycling.[309]

Falls are the leading cause of nonfatal unintentional injuries for children younger than 18 treated in emergency rooms.[310] In 2000, falls among this age group accounted for an estimated 2.6 million emergency department visits.[311]

Alcohol-Related Accidents

Alcohol use and abuse by adults and minors is a major factor in many accidental injuries and deaths of children and youth. It is a contributing factor in up to 50% of drownings among adolescent boys.[312, 313] It contributes to accidental residential fires and to motor vehicle accidents. In 1998, 38% of traffic fatalities were alcohol related, with either the driver or an affected person (e.g., a pedestrian or a bicyclist) having a blood alcohol concentration of at least 0.01 gram per deciliter (g/dL).[314] As noted earlier in this chapter, abuse of alcohol and other drugs is also a major factor in many child neglect cases, which often involve accidental injuries of children due to lack of supervision.[315]

Promising Solutions

Community-Based Injury Prevention Programs

T. P. Klassen and associates offer the following common elements of successful community-based approaches to injury prevention:[316]

- The use of multiple strategies grounded in a theory of behavior change.
- The integration of interventions into the community and the tailoring of approaches to meet unique community needs.
- The inclusion of community stakeholders in the development of community-based strategies. This community involvement and ownership of the intervention increases the likelihood of modeling and peer pressure, leading to widespread adoption of a safety behavior.
- The use of a randomized controlled design to evaluate the program will maximize the trustworthiness of reported findings and aid decisions about where to invest resources in community-based approaches to injury prevention.

Motor Vehicle Safety

Child safety seats reduce the risk of death by 70% for infants and 55% for toddlers. For children age 9 and older, a seat belt can reduce the risk of death by 50%. The Centers for Disease Control and Prevention recently found that laws requiring the use of child safety seats are effective in decreasing fatal and nonfatal injuries, and in increasing child safety seat use.[517] Riding in the back seat of a car can reduce the risk of death by 46%. Children ages 4 through 8 should be restrained in a booster seat.[518]

MODEL PRACTICE

The Safe Kids Campaign joined with General Motors in 1997 to promote car seat and safety belt use for children across the United States. The Safe Kids Buckle Up program is designed to prevent motor vehicle tragedies through an information hotline, car seat check-up events, free car seat distribution, and education workshops. To date, 38 people say their children's lives were saved as a result of the program.

The National Safe Kids Campaign. See www.safekids.org/index.cfm.

Community-wide information and enhanced enforcement campaigns increased child safety seat use by a median of 12%. Child safety seat distribution and education programs increased both possession of and proper use of safety seats by a median of 23%. Distribution programs were effective when implemented in hospitals and clinics, as part of postnatal home visits, and when provided by an auto insurance company.[519]

National group rides and designated drivers, 0.08% blood alcohol concentration (BAC) laws, minimum legal drinking age laws, sobriety checkpoints, lower BAC laws for young and inexperienced drivers, and training programs for people who serve alcoholic beverages have also had success in reducing alcohol related fatalities.[520]

Laws raising the minimum legal age for drinking reduced crash-related outcomes by a median of 16% for the targeted age groups, whereas lowering the age was accompanied by a median 10% increase in crash-related outcomes.

MODEL PRACTICE

The **Oklahoma City Smoke Alarm Project** is a community intervention instituted to reduce fire-related injuries and deaths in Oklahoma City. Smoke alarms were distributed to target neighborhoods along with educational pamphlets. During the six years following the project, within the target population, the residential fire-related injury rate decreased 81%. Throughout the rest of Oklahoma City where the smoke alarms were not distributed and no increased educational efforts were made, however, the residential fire-related injury rate decreased 7%.

See http://www.futureofchildren.org/information2826/information_show.htm?doc_id=69769.

Fire Safety

Although smoke alarms cut the chances of dying in a house fire by 40% to 50%, about one-quarter of U.S. households, often those in low-income areas, lack working smoke alarms.[521]

Bicycle Safety

Bicycle helmets are the most effective safety device for reducing head injury and death while bicycling. The risk of head injury is reduced by 85% if the person is wearing a helmet.[522] More than 70% of children between 5 and 14 ride bicycles (27.7 million), yet only 15% to 25% wear helmets.[523] Of high school students who rode a bicycle during the past 12 months, 85% rarely or never

wore a bicycle helmet. The primary strategies to increase bike helmet use include education, legislation, and helmet-distribution programs. Some evidence suggests that legislative efforts are more cost-effective than school- or community-based programs.[325]

PROTECTION FROM ENVIRONMENTAL TOXINS

The Need

Lead poisoning, environmental tobacco smoke, and drinking water contamination are common environmental toxins that cause myriad health problems in children and youth.

Children can swallow harmful amounts of lead by playing in the dirt or in dusty areas and then putting their fingers, clothes, or toys in their mouths, or by eating without first washing their hands. Exposure to excessive levels of lead can cause brain damage; affect a child's growth; damage kidneys; impair hearing; cause vomiting, headaches, and appetite loss; and cause learning and behavioral problems. Fetuses, infants, and children are more vulnerable to lead exposure than adults because lead is more easily absorbed into growing bodies. Also, the tissues of small children are more sensitive to the damaging effects of lead.

Environmental tobacco smoke (ETS) results primarily from smoke emitted from the burning end of a cigarette, cigar, or pipe, as well as smoke exhaled by a person smoking. ETS is dangerous to unborn fetuses, increasing the risk for perinatal death and miscarriage.[326] In 1992, the Environmental Protection Agency classified ETS as a "Class A" human carcinogen, extremely dangerous for humans, and it has been found to increase the risk of, or potentially cause, pneumonia, bronchitis, asthma, otitis, and a significant reduction in lung capacity in children and youth.[327]

The tap water available to many in America is contaminated with toxic and cancer-causing chemicals such as lead, trihalomethanes, arsenic, radioactive materials, and pesticides.[328] Children are more vulnerable to drinking unhealthy water than adults because they drink a lot more water than adults in proportion to their body weight.[329]

Children clearly need protection from environmental toxins through a variety of regulatory, preventive, and intervention approaches.

The Challenge

The Learning Disabilities Association and the National Institute of Environmental Health Services (NIEHS) recently called on Congress and all regulatory agencies to institute neurotoxicity testing for food additives, pesticides and drugs to find out how they contribute to the current endemic increase in learning disabilities in children.[330] The two groups estimate that those affected include an estimated 12 million U.S. children younger than 18.[331]

Lead Poisoning

An estimated 1.7 million U.S. children have unsafe blood-lead levels.[332] The major sources of lead exposure are deteriorated paint

MODEL PRACTICE

Hartford's Healthy Homes has coordinated the multiple medical, social, and outreach services that are needed to treat lead poisoning, along with asthma and other health hazards and injuries. This program has engaged nurses and outreach workers in targeted education to families within greater Hartford through direct one-on-one education in homes, health fairs, local presentations, community education, and advocacy.

The program accepts referrals from primary care providers and local agencies to evaluate homes for environmental hazards and funnels these through an on-site social worker. The social worker coordinates the limited provision of supplies such as mattress covers, smoke detectors, window guards, and bath thermometers. Housing improvements are coordinated with landlords. A safe house serves to temporarily house families with lead poisoned children or other housing related environmental hazards. The social worker engages the entire family and coordinates other activities such as involvement in social service, welfare to work, and parenting programs.

To date the program has seen a decrease in emergency room use, clinic visits, hospitalizations, and school absenteeism.

For more information, contact Teresa A. Allen, Registered Nurse, at 860/714-4792 or tallen@stfranciscare.org.

MODEL PRACTICE

The **Massachusetts Tobacco Control Program** (MTCP) is a statewide public health initiative composed of activities and services that promote smoking prevention and intervention. The goals of the initiative are to: prevent young people from smoking, persuade smokers to stop smoking, and protect nonsmokers by reducing exposure to ETS. The program emphasizes community education and local participation in policy initiatives. An independent evaluation found that statewide between 1993 and 1999, cigarette consumption fell 32%; smoking during pregnancy dropped from 25% to 13%; youth smoking rates stayed the same even though they increased nationwide; exposure to ETS was reduced in workplaces, restaurants, and other public buildings; and successful attempts of underage teenagers to buy cigarettes dropped from 48% to 10%.

See http://www.state.ma.us/dph/mtcp/home.htm.

MODEL PRACTICE

The **Collaboration for Public Water** in Buckhorn, Kentucky is a team effort of the Corps of Engineers, the State Park, the county school system, and the Presbyterian Child Welfare Agency to bring safe drinking water to the children and families in the area. Success in eliminating the costs and health risks associated with the traditional supply of well water required two years of effort, the investment of nearly a million dollars by the agencies, and the area's incorporation as a city. As a result, the Village of Buckhorn began operating the Buckhorn Water Company, serving the needs of the four agencies and 250 families in the surrounding communities. Additionally, their cash investment leveraged more dollars in a grant to serve the low-income families of the community.

For more information, contact Charles L. Baker at 606/398-7000 or charlie.baker@buckhorn.org.

in older housing, and soil and dust that are contaminated with lead from past emissions of leaded gasoline and from old paint.[333]

Environmental Tobacco Smoke

Environmental tobacco smoke (ETS) aggravates episodes and severity of asthma attacks in 200,000 to 1,000,000 asthmatic children a year, and causes more than 8,000 new cases of asthma in children each year.[334] ETS is estimated to be at least partially responsible for the deaths of up to 6,000 children per year.[335, 336]

Drinking Water Contamination

According to Environmental Protection Agency (EPA) data, more than 29 million people drank water served by systems with coliform bacteria exceeding the EPA's health standards; 19.6 million Americans drink water from systems that failed to meet the EPA's basic treatment standards.[337]

Some small, rural, and low-income communities and many communities of color do not have safe and affordable water supplies, putting their children at higher risk of waterborne diseases. One study found that there are "clear situations where certain [racial and socioeconomic] populations are exposed to higher levels of contaminants in water" than the general population.[338] High rates of contamination of drinking water have been documented on American Indian reservations and in migrant farm workers' camps with predominately Hispanic populations.[339] A threefold increase in rates of waterborne disease and hepatitis A was also found in Texas border counties.[340]

Promising Solutions

Protecting children from the impact of environmental toxins in some cases can be very simple. Removing old paint from a door or filtering drinking water, for example, can be a significant step towards protecting children's healthy development.

In other cases, broader community or countywide interventions must take place to improve the underlying environmental conditions, educate the public, and provide adequate identification and treatment services for those who have been harmed. For example, many communities have improved their drinking water through regulations, public education, and pressure on businesses to use feasible, nonpolluting alternatives that make economic sense.

Healing

"One of our counselors once asked a child to draw a picture of what helped her cope with fear. She filled her paper with people and places, including her mother, her grandmother, her teacher, her church, and a police officer. She explained that these people helped her in different ways and that they were all important. This picture has come to represent our vision about who we must involve in the effort to help children affected by violence."

—Betsy McAlister Groves, Children Witness to Violence Project[341]

Parents, kin, teachers, clergy, and justice and human service professionals all have roles to play in helping children and youth to heal from trauma. Feeling loved and cared for gives many children who have been victimized the strength and optimism to see themselves through difficulties.

Often we overlook the extraordinary talents of children and youth who do well in the face of adverse situations, as well as the factors that supported their resiliency. Although childhood victimization can cause neurological and medical, cognitive, social, behavioral, and psychological consequences that may persist through adulthood, the positive effects of protective factors and interventions are available at all ages.[342]

As children who have been traumatized grow older, resilience can emerge through the development or strengthening of insight, independence, positive relationships, initiative, creativity, humor, and morality.[343] Parents, caregivers, professionals, and others can actively promote a child's healing from harm by strengthening an array of protective factors such as the child's self-esteem, self-efficacy, and competence in roles such as student, friend, worker, or athlete. The presence of a caring and supportive adult, positive parent-child relationships, and effective parenting,[344] along with opportunities in the broader environment for education, employment, growth, and achievement are additional protective factors that promote healing.[345]

PROTECTION, CARE, AND SUPPORT IN RESPONSE TO TRAUMA

The Need

Children and youth may suffer a variety of injuries and conditions as a result of neglect, physical and sexual abuse, accidents, witnessing violence, and exposure to environmental toxins. Early identification of the effects of trauma, emotional support from significant others, and prompt and proper medical and mental health care may ease the impact of harm.

Children who have been harmed are best served when their parents, kin, and other caregivers, along with the professionals involved in responding to the crisis, cooperate in ensuring the child's safety, meeting their immediate needs for emotional support and treatment, and, if necessary, linking them to appropriate ongoing services and supports.

The Challenge

Recurrence of Child Maltreatment

Efforts of the child protection system and others in the community do not keep all abused and neglected children and youth safe from subsequent harm. In 1999, based on data from 20 states, 1 in 13 child victims (7.5%) suffered a subsequent incident of abuse or neglect within six months of the initial substantiated or indicated maltreatment.[346]

This reoccurrance may be due, in part, to the fact that in the same year, nearly half of families who experience abuse and neglect (45%) received no services through the child welfare system following CPS investigation.[347] Service delivery tends to be uneven across com-

BEST COPY AVAILABLE

munities, with particular shortages of services offered in languages other than English. Obstacles include insufficient service availability, long waiting lists, and the voluntary nature of some service provision.[348]

We also have not been successful in finding effective ways to decrease violent behavior. "Neither arrest nor mandatory or voluntary treatment has been shown to have a significant effect on reducing men's violent behavior toward members of their families."[349]

Promising Solutions

Identifying Early Signs of Distress

Children and adolescents show a wide range of immediate and short-term reactions to traumatic events. These reactions include anxiety, fear, depression, anger, and withdrawal. Fear of the event recurring and loss of trust in adults are common responses. Often, the more direct the exposure to the traumatic event, the higher the risk for emotional harm.

Children's early responses to traumatic events are often adaptive, but not necessarily constructive. For example, being tough or violent may be a rational adaptation in the short term, but continued exposure to violence may lead children to accept violent responses as the preferred means to solve problems.[350]

The earlier that harm to children and youth is detected, the easier it can be to remedy its impacts. Parents and caregivers, school personnel, health professionals, and other community members who interact with children and youth should be familiar with the behavioral and physical signs that may indicate that children/youth have been victimized or injured. Common signs of distress in children and youth in the days and weeks following a traumatic experience include:[351]

- **Sleep disturbances**: frequent nightmares, waking in the night, bedwetting.
- **Separation anxiety**: refusing to go to school, upset when left with babysitter or child care provider.
- **Hypervigilance**: worried, fearful, easily startled.
- **Physical complaints**: headaches, stomach aches, and other aches and pains with no clear medical cause.
- **Irritability**: increased aggressive behavior, angry outbursts, difficult to soothe.
- **Emotional upset**: tearfulness, sadness, talking about scared feelings or scary ideas.
- **Regression**: loss of skills learned at an earlier age, "babyish" behavior.
- **Withdrawal**: loss of interest in friends, school or other activities child used to enjoy.
- **Blunted emotions**: shows no feelings at all, not bothered by anything, dissociation.
- **Distractibility**: trouble concentrating at school or home, daydreaming.
- **Changes in play**: repeatedly acting out violent events in play, less able to play spontaneously and creatively.

Culturally Competent Service Provision

Considerations of culture, ethnicity, and religion are of paramount importance in both immediate and longer-term professional responses to childhood trauma. Understanding values and attitudes about certain behaviors, respect for elders, the use of physical punishment, privacy, sharing family matters, and sexuality can impact whether certain services are appropriate and

accepted. In addition, service providers must also address family perceptions about the helpfulness and purpose of services.[352]

Service interventions are a reflection of the broader society in which we live. Interventions are developed and implemented with a cultural lens... a philosophy and approach to helping and serving victims and their families. Unless a concerted effort is made to do otherwise, services typically embrace the methods of the dominant culture. Culturally appropriate services, though available, are in limited supply.

Formal service systems, in pursuing mainstream practice assumptions, are often challenged to adequately address the needs of those who are "different" in our society. Acknowledging, understanding, and responding to cultural differences provide us with an opportunity to ensure that vulnerable children and youth are adequately nurtured and served.

Sensitive Crisis Responses

Sensitive crisis responses to children who have been harmed ensure the child's safety, meet their immediate needs for support and treatment, and link them to appropriate on-going services and supports.

First responders–those emergency personnel called to the scene of a crisis or responding to emergency calls for assistance–can include emergency medical technicians, police, hotline/crisis line personnel, fire and rescue, child protective services and others. According to a U.S. Department of Justice handbook for first responders, "The way people cope as victims of crime depends largely on their experiences immediately following the crime."[353] Stress reactions can actually be intensified by the very people and systems that are expected to assist them in times of crisis. This second injury or secondary victimization can be more psychologically damaging to victims than the original traumatic event.[354]

Sources of secondary victimization include family, friends, co-workers, employers and acquaintances; the criminal justice, child welfare, and mental health systems; and others such as medical personnel, teachers, and clergy.[355] Thus, it is of extreme importance that parents and other family members receive the support they need to deal with their own anger, shock, and anxiety, thus allowing them to be more available to and supportive of their children.

First responders need to understand and meet the three major needs of victims: the need to feel safe, the need to express their emotions, and the need to know "what comes next."[356] They should be trained in child development and adept at engaging, interviewing, and treating children and youth, and at involving their families in decisionmaking and treatment.

Differential Responses to Reports of Child Abuse and Neglect

More than a dozen states encourage and provide for more than one type of initial response to reports of child abuse or neglect. Although models vary in their design and operation, all seek to increase the flexibility, responsiveness, and cost-effectiveness of the child welfare agency. In situations where the risk of harm to children is determined not to justify court involvement, family

MODEL PRACTICE

In response to state legislation calling for more flexible responses to reports of child abuse and neglect, Missouri created a **dual-track** approach. Beginning in pilot areas, the approach screened child protection hotline calls into one of two tracks, investigation, or family assessment. During the pilot, 71% of the reports were screened for family assessment and 29% for investigation. Evaluation of the pilot sites found that child safety was not compromised, hotline reports declined, reported incidents in which some action was taken increased, community resources were better utilized, and families were more satisfied and felt more involved.

Schene, P. (2001, Spring). *Meeting each family's needs. Using differential response in reports of child abuse and neglect.* Washington, DC: National Resource Child Welfare Resource Center for Family-Based Practice. Available from http://www.cwresource.org/hotTopics/DiffResponse/MeetingEaFamNeeds.htm.

assessments are conducted and community services are offered to the family to prevent problems from escalating. Higher risk cases that may involve criminal charges are formally investigated by child welfare caseworkers, most often in conjunction with law enforcement. Evaluations of these "dual track" systems suggest that they can produce positive changes in child safety, family satisfaction, and community involvement in child protection.[557]

Coordinated Crisis Responses to Child Abuse and Neglect

When child abuse, neglect, or other victimization has occurred, timely and collaborative investigative processes and intensive interventions with child victims and their families can prevent further abuse and reduce negative impacts.[558] In many communities, however, law enforcement, CPS, and other systems operate in isolation from each other when responding to child victimization. Differences in philosophies, cultures, roles, and resources, as well as a lack of interagency protocols and training, create obstacles to the close multidisciplinary coordination needed to effectively protect children.

A growing body of research supports a coordinated multiagency approach as an effective means to achieve better protection of children. More than three-quarters of the states have statutes authorizing some type of multidisciplinary team, although the application of these statutes varies considerably across states and localities. One study evaluating the effectiveness of the multidisciplinary approach based on actual service delivery found that working in teams reduces fragmentation and duplication of efforts, provides for case coordination, and may increase the probability that families receive necessary services.[559]

Family Group Decision-Making

Family group decision-making (FGDM) is a type of family group conference that engages families in planning for child safety and permanency in situations where abuse or neglect has occurred. FGDM is anchored in two guiding principles: (1) children do better when they can maintain strong connections to their primary caregivers, and (2) interventions that involve family members in determining how children should be cared for empower and strengthen families.[560]

Family Preservation Services

For some families that experience abuse and neglect, home-based interventions can be effective at keeping children safely at home while reducing the risk of further maltreatment. Intensive Family Preservation Services are designed to prevent the unnecessary out-of-home placement of children through intensive, on-site intervention, and to teach families new problem-solving skills to prevent future crises.

MODEL PRACTICE

An increasing number of communities have developed **Child Advocacy Centers** (CACs) that bring together five core disciplines: law enforcement, child protective services, prosecution, mental health, and health care. Communities where CACs exist have documented more immediate follow-up on child protection reports, a reduction in the number of interviews of each victim, and increased successful prosecution.

See National Children's Alliance website: http://www.nca-online.org.

MODEL PRACTICE

A Family Group Decision-Making demonstration project in Michigan, now involving six counties, supports an increased role of family in the care and protection of children, and creates a family support system focused on safety and stability, with the development of formal plans to guide and assess success. In 2000, 75% of Michigan families participating in this process had their cases closed, having successfully achieved their goals.

Beougher, J. E. (2001, May 10). Testimony submitted to the U. S. House of Representatives' House Ways and Means Committee, Subcommittee on Human Resources. Hearing on Promoting Safe

MODEL PRACTICE

HOMEBUILDERS, the oldest intensive family preservation services program in the United States, provides intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of placement in state-funded care. Since 1974, HOMEBUILDERS has provided services to more than 15,000 families. Recent data show that six months after termination of services, 86% of children have avoided placement in state-funded foster care, group care, or psychiatric institutions, and remained safely in their homes. Pre-post measures within the family show a substantial reduction in risk across a variety of factors.

For more information, see the Institute for Family Development website: http://www.institutefamily.org/.

Placement Decisions

Decisions to place children or youth outside of their homes are often made when their safety or the safety of their family and community cannot be assured if they remain at home. Out-of-home placement is traumatic to children, and can have significant psychological, social, and behavioral consequences.[361] Intensive, in-home services should be available and employed to keep children and youth safely at home whenever possible.

Rycus and Hughes assert that, "There are two truisms in child placement. The first is that the only legitimate justification for out-of-home placement is that supportive family services and other interventions cannot assure protection of children in their own homes. The second is that children should never be left in a home when they cannot be protected from abuse and neglect."[362]

If placement is necessary, all efforts should be made to reduce the trauma to the child by minimizing the changes (culture, diet, neighborhood, school, place of worship) to which they must adapt. Children should be placed in a setting that meets their needs and is as homelike (least restrictive), and as close to their own homes as possible. Such placements allow children and youth to more easily preserve their connections to the people they care about and who offer them emotional support, such as siblings, relatives, teachers, and neighbors. The Annie E. Casey Foundation's Family-to-Family reform initiative focuses on strengthening the network of families available to care for abused and neglected children in their own communities.[363]

Kinship care, discussed earlier, provides care by a relative. Family foster care can also provide nurturing and safe care for children and youth. Children who enter family foster care usually require temporary placement outside of their family. Some children, however, remain in foster care for extended periods of time.[364] A guiding principle for The Casey Family Programs' National Center for Resource Family Support is that "foster care is a healing process for children and their families in the context of their respective communities."

Services for Children Witnessing Domestic Violence

Given the high rate of co-occurrence between partner abuse and child abuse, it is imperative that we develop the coordinated service responses needed to effectively assess safety and provide the services and supports needed to help protecting parents achieve safety for themselves and their children.

Over 2,000 domestic violence shelters provide transitional living and counseling services for women and their children.[365] The majority of children exposed to domestic violence do not have access to these services, however, and new strategies for identifying and serving these children must be developed.[366]

Over the past decade, the immediate and long-term consequences of children witnessing domestic violence have been explored and documented. As a result, information is available on the impacts of witnessing family violence, expanded training opportunities for service providers, and effective assessment and intervention approaches to assist those who have witnessed family violence as children.[367]

MODEL PRACTICE

The **San Diego Children's Hospital Family Violence Program** assists battered mothers in their efforts to establish a safe environment for their children and themselves. Serving 120 women and 350 children each year, the program pairs battered women and their children with a two-person team consisting of an advocate and a therapist. Mother and child receive free intensive advocacy, legal consultation, and mental health services. The children are often treated for Posttraumatic Stress Disorder (PSTD) and receive a range of preventive and therapeutic interventions. At intake, 88% of the participants reported physical assault; six months later, the level of physical violence the women experienced had decreased to 10%. The proportion of children exposed to family violence decreased from 85% to 20%.

Office for the Victims of Crime. (1999, June). *Breaking the cycle of violence: Recommendations to improve the criminal justice response to victims and witnesses* (NCJ #176983). Washington, DC: U.S. Department of Justice.

CONTINUING PROTECTION, CARE, AND SUPPORT

The Need

After the immediate crisis response, children and youth continue to need protection and support. They may also need access to sensitive and effective long-term treatment.

The Challenge

A growing body of research is available on the effectiveness of particular interventions at easing the impact of specific harms on children and youth. Clearly, however, the field needs more longitudinal prospective studies.

Mental Health Outpatient Treatment Outcomes

Research in actual practice settings is underway to test the effectiveness of various forms of outpatient mental health treatment for children. At this time, however, nearly all research has been done in controlled research settings. This research has demonstrated that outpatient therapy resulted in greater improvements than those achieved without treatment.[568] The few studies done on children treated in nonresearch clinical settings, however, showed that the treatment had little or no effect.[569]

The Child Welfare, Mental Health, and Juvenile Justice Systems

The child welfare, mental health, and juvenile justice systems provide services to many children and youth who have been harmed. Often, a child or youth is involved with two or three of these systems successively or simultaneously. For example, children in the child welfare system entering out-of-home care typically have significant mental health and/or developmental problems.[570] Upon admission to juvenile facilities, 73% of juveniles reported having mental health problems, and 57% reported having prior mental health treatment or hospitalization.[571]

The families of children in these systems often have multiple and overlapping problems, while services tend to be uncoordinated and delivered in separate locations.[572] Over the past two decades, recognition has increased of the merit and necessity of collaboration among these systems, the education system, and community providers involved with a certain child or youth, and his or her family. Often, however, this goal is not reached. All three systems have also articulated and attempted to implement services that are strength based, family focused, comprehensive, and culturally competent.

Promising Solutions

Treatment for Abused and Neglected Children, Youth, and Their Families

Specific brief, cognitive behavioral interventions are among the most effective treatments for children who have been abused and neglected. Involvement of parents, regardless of whether they are the abusers, enhances outcomes.[573]

Substance Abuse Treatment for Parents

Substance abuse problems often are longstanding and subject to high rates of relapse after treatment; they also significantly de-

MODEL PRACTICE

The **Sobriety Treatment and Recovery Teams** (START) program of the Cuyahoga County Department of Children and Family Services in Cleveland, Ohio, works with women who deliver babies at five area hospitals and who show a positive toxicology screening for any drug. START team members provide in-home services, making at least one home visit per week per family, and ongoing protective services. Drug assessment and treatment is available within 72 hours of intake. Families have access to their workers 24 hours a day, seven days a week.

START mothers were much more likely to begin substance abuse treatment than comparison group mothers (91% vs. 53%), and remained in treatment an average of 134 days. Infants of START mothers also spent fewer days in juvenile court custody than did infants of comparison group mothers (340 days vs. 519 days).

See http://www.aecf.org/initiatives/familytofamily/tools/startsummary.pdf.

crease the ability to parent. In a 1997 CWLA survey, child welfare agencies reported that they were able to provide substance abuse treatment services to less than one-third of the families who required it. In most states studied, the wait for treatment services was up to 12 months.[374]

Programs that provide a continuum of substance abuse treatment services, addressing caregiver's health, psychosocial, environmental, and parenting needs, as well as the needs of their children, promote self-sufficiency, child safety, and family well-being.[375]

Services for Delinquent Youth and Their Families

To intervene effectively with children and youth who have broken the law, programs and services must address the multiple needs of these children across areas such as education, family functioning, and physical and mental health.[376] According to the Coalition for Juvenile Justice, effective programs for young offenders should provide:[377]

- Development of basic social skills;
- Individual counseling that directly addresses behavior, attitudes, and perceptions;
- Sensitivity to a youth's race, culture, gender, and sexual orientation;
- Family member involvement in the treatment and rehabilitation of their children;
- Community-based, rather than institution-based, treatment;
- Service, support, and supervision that "wrap around" a child and family in an individualized way;
- Recognition that youth think and feel differently than adults, especially under stress; and
- Strong aftercare services.

Comprehensive, Needs-Based Interventions

Current research indicates that comprehensive, needs-based interventions generate the strongest and most significant reductions in juvenile criminal behavior.[378]

Restorative Justice Practices

Restorative justice practices attempt to lessen the harm resulting from crime through methods that benefit the victim, the offender, and the community. Restorative justice practices, such as victim impact statements, sentencing circles, and family group conferencing, appear to be promising means of easing the impact of harm on children and youth who are the victims of crime.

Ron Claassen, Director of the Center for Peacemaking and Conflict Studies, states, "Restorative justice recognizes that (after crime occurs) there are dangers and opportunities. The danger is that the community, victim(s), and/or offender emerge from the response further alienated, more damaged, disrespected, disempowered, feeling less safe and less cooperative with society. The opportunity is that the injustice is recognized, the equity is restored (restitution and grace), and the future is clarified so participants are safer, more respectful, and more empowered and cooperative with each other and society."[379]

MODEL PRACTICE

Multisystemic therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as nested within a complex network of interconnected systems that encompass individual, family, and extra-familial factors. Intervention may be necessary in any one or in a combination of these systems.

Evaluations of MST have demonstrated reduced long-term rates of criminal offending in serious juvenile offenders; reduced rates of out-of-home placements for serious juvenile offenders; reduced self-reports of alcohol and marijuana use; extensive improvements in family functioning; decreased mental health problems for serious juvenile offenders; and cost savings in comparison with usual mental health and juvenile justice services.

Multisystemic Therapy Services. (1998). *Multisystemic therapy at a glance*. Available from http://www.mstservices.com/text/treatment.html.

A Victim Impact Statement (VIS) is a victim's written or verbal description of how the crime affected them and their loved ones. A VIS can help courts and parole authorities to understand the physical, psychological, and financial effects of the crime on the child victim and his or her family members.[580]

The use of a VIS is a restorative practice that can assist in holding offenders accountable for their criminal or delinquent actions, and involve victims in a meaningful way in what may be one of the most significant events of their lives. A VIS can help child victims to understand that they are being taken seriously and that they are being believed by those in authority.

Sentencing (or peacemaking) circles involve the victim, victim supporters, the offender, offender supporters, judge and court personnel, prosecutor, defense counsel, police, and all interested community members in reaching consensus on an appropriate sentencing plan that addresses the concerns of all interested parties. Within the circle, people can speak from the heart in a shared search for understanding of the event, and together identify the steps necessary to assist in healing all affected parties and prevent future crimes. The offender applies to participate in the circle process. Healing circles are held for the victim and for the offender prior to the initiation of the sentencing circle. In addition, follow-up circles are convened to monitor the progress of the offender. The circle process is not appropriate for all offenders. The process is designed locally in accordance with community culture and needs.

Family group conferencing involves the victim, the offender; and the family, friends, and key supporters of both, in deciding the resolution of a criminal incident. A trained facilitator convenes these affected parties to discuss the harm resulting from the offense and how best to repair it.[581]

Preliminary U.S. program evaluations report high levels of victim satisfaction with the process and high rates of compliance by offenders with the agreements reached during conferences. Practitioners observe a reduction in fear for many victims.[582] Further research is needed to measure the impact of family group conferencing on child victims.

Services to Mentally Ill Children and Youth, and to Their Families

Promising practices for "systems of care" address the mental health needs of children with serious emotional disturbances and their families. Systems of care are characterized by:[583]

- Services that are community-based, individualized (built on the strengths and needs of children and families across life domains to promote success, safety, permanence in home, school and community), and culturally competent (built on the unique values, preferences, and strengths of children and families and their communities);
- Full and active partnerships with families throughout the process;
- Team-driven decisions involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate an individualized service plan;
- Adequate, flexible approaches and flexible funding;
- A balance of formal services and informal community and family resources;
- An unconditional commitment to serve children and their families; and
- Plans to meet needs that are developed and implemented based on an interagency, community-based collaborative process;
- Outcome measure systems, program, individual child, and family performance and results.

Evaluations of systems of care have shown their effectiveness in reducing the use of residential placements and out-of-state placements, and in improving functional behavior. Parents report more satisfaction with systems of care than with more traditional mental health system approaches.[584] The cost-effectiveness of systems of care is not yet clear, nor is their impact on clinical outcomes.[585]

MODEL PRACTICE

Outcomes for youth participating in ***Wraparound Milwaukee*** have been encouraging. The use of residential treatment has decreased 60% since the initiation of the program. Inpatient psychiatric hospitalization has dropped by 80%. The average overall cost of care per child has dropped from more than $5,000 per month to less than $3,300 per month. The delinquent youths' functioning at home, at school, and in the community has improved significantly. A statistically significant reduction has also been seen in recidivism rates for a variety of offenses for youth enrolled in the program.

Kamradt, B. (2000). Wraparound Milwaukee: Aiding youth with mental health needs. *Juvenile Justice, 7*, 14–23.

Wraparound Service Programs

Wraparound service programs provide treatment that is tailored to the needs of each seriously emotionally disturbed (SED) youth. The Wraparound philosophy is specifically oriented toward individualized care, flexible programming, and a "never give up" philosophy.[586]

Specific elements of Wraparound programming include: adoption of intervention approaches that draw on the strengths, as opposed to deficits, of children and families; active involvement of families in the treatment process; provision of needs-based service planning and delivery; individualized service plans; and outcome-focused treatment processes.[587] Individualized care is provided through care coordinators, child and family teams, mobile crisis teams, and a provider network composed of a wide range of local and state agencies.[588]

Out-of-Home Placement

Each year in the United States, hundreds of thousands of children and youth reside in out-of-home care in the child welfare, mental health, and juvenile justice systems, usually by order of the juvenile court.

The major goals of out-of-home placement are child safety, child well-being, and permanence. Children and youth in out-of-home care have the same universal needs as do other children. Caregivers and agency staff must meet their basic needs, ensure nurturing relationships, protect them from harm, see that they receive the support and treatment needed to ease the impact of the harms they have suffered, and provide access to opportunities for their optimal development.

Treatment Foster Care

Children are referred to Treatment Foster Care (or Therapeutic Foster Care) programs (TFC) to address their serious emotional, behavioral, and medical problems. Treatment Foster Care is a clinically effective and cost-effective alternative to residential treatment facilities. It combines the treatment technologies typically associated with more restrictive settings with a nurturing and individualized family environment. In Treatment Foster Care, key intervention and supports are provided by treatment foster parents who are trained, supervised and supported by agency program staff.[589]

Research studies on TFC indicate that while in TFC placements, most youth improve on behavioral indicators of adjustment[590] and have more stability and less restrictiveness in their postdischarge living situations than youth served in group care settings.[591]

Residential Care

Residential group care and treatment programs serve children and youth with serious emotional, physical, and behavioral conditions that require intensive therapy. These highly struc-

tured programs offer an array of therapeutic, educational, and treatment services. They are designed to meet each child's individual needs and vary in client's length of stay. Residential care placements are the costliest child welfare service.[392]

A 1994 U.S. General Accounting Office report noted that exemplary residential treatment programs had several characteristics in common. Among these were family involvement, skills teaching, and post-program planning and support.

Chapter Five cited the Work Appreciation for Youth (WAY) program of the Children's Village in Dobbs Ferry, New York, as a model practice.

MODEL PRACTICE

Vista Del Mar, located in West Los Angeles, provides residential treatment services to youth whoare typically unable to function in foster care or other therapeutic settings. In 1999, the program introduced a health and wellness component to its program. The program has three goals: to provide youth with the information needed to become happy, productive adults; to prepare them for employment and transitional living; and to provide them with counseling that addresses their needs as they transition from residential care to the community. In the first two years, 60% of participants completed the Health and Wellness program. These 12- to 19-year-olds, more than half of whom were boys, showed significant improvement in 10 areas related to transitional living including money management, health and food management, education, job seeking and maintenance, emergency and safety, legal issues, behavior toward others, substance abuse, and mood/self-harm.

Making Children a Community Priority

The extent to which all of America's children are healthy, safe, and thriving will depend, in large part, on actions taken in local communities. Communities are the most promising context within which children and families can be encouraged to contribute their gifts, and receive from others the care and support that will meet children's universal needs. This reciprocity, in which community members recognize that they need and can depend on one another, is one of the most powerful sources of community and family strength.[393] By weaving connections with one another, people bring new possibilities and capacities into play, and individuals are "sustained by currents of power larger than one's own."[394]

Though some analysts define *communities* simply as "geographic areas based on political jurisdictional boundaries,"[395] the Framework proposes that communities are defined as much by shared values and networks of relationships as by geography. They encompass individuals, civic, and neighborhood organizations; religious groups; public and private sector service providers; public agencies; and elected and appointed officials. We are all members of interwoven communities defined by faith, values, culture, geography, and shared history, and our diversity can lend great strength and flexibility to our collective efforts in behalf of children.

Although much has been written in recent years lamenting the disintegration of communities and the breakdown of family bonds, throughout human history, processes of regeneration have always been at work that can counter the forces threatening our social networks. "Humans are community-forming animals"[396] and human communities, like all living systems, are innately resilient.

CIRCLES OF SUPPORT

If a community truly met children's universal needs, a *circle of caring relationships* with extended family members, friends, neighbors and coworkers would surround and sustain families. "A wide cushioning band of *helping institutions*,"[397] composed of schools, faith-based groups, community organizations, libraries, recreation centers, hospitals, health centers, and voluntary agencies that help *all* young people and their families develop their talents, knowledge, and skills would support this primary social network. Outside of these two circles, a third, much narrower band of *specialized crisis intervention and treatment services*, provided by public and private agencies responsible for child welfare, income maintenance, juvenile justice, mental health and substance abuse treatment, would help those for whom prevention is not enough.

In a healthy community, families are free to move back and forth among these interconnected circles of support to find the degree and kind of help they need, and are encouraged to develop their own strengths and self-reliance. Professionals and government officials can provide expertise and resources essential to supporting and strengthening communities and families at all three levels.

THE POWER OF COMMUNITIES

Communities can implement many proven and promising strategies for meeting children's universal needs. Though actions taken by individuals can combine to cause significant improvements in the quality of life for children, youth, and families, the power of intentional community-based collaboration to produce positive change is even greater.

Developing sound and sustainable partnerships is key to effectively addressing issues that affect whole communities. Strategies that balance grassroots activism with the support of those in positions of authority and influence have the greatest chance of successfully meeting the needs of children and families.

Community-based collaboratives have the potential to engage a broad spectrum of individuals in the essential work of nurturing our children. They can empower children, youth, and families to become full participants in community change.

Professionals and community members must move away from seeing community members as passive consumers or recipients of services. Community members should be encouraged to see themselves as active contributors to their own and their communities' well-being.

The Laidlaw Foundation, which has explored social inclusion as a "way of re-focusing child and family policy," outlines five critical dimensions[598] that are also the cornerstones of healthy communities:

1. **Valued recognition:** Conferring recognition and respect on individuals and groups, and understanding that differences are better seen as sources of strength rather than as indicators of pathology.
2. **Human development:** Nurturing the talents, skills, capacities, and choices of children and adults to live as they and others value.
3. **Involvement and engagement:** Having the opportunities and supports necessary to be involved in decisions that affect self, family, and community, and to be engaged in community life.
4. **Proximity:** Sharing physical and social spaces that make interaction and communication possible.
5. **Material well-being:** Having adequate resources to meet the basic needs of children and families.

RESHAPING PROFESSIONAL ROLES

To successfully partner with communities and families, professionals and government officials must renew their faith in the vitality and resilience of communities, and commit themselves to policies based on social inclusion.[599]

Recognition is growing that professional roles and practice must be reshaped if public agencies are to effectively partner with communities to meet the needs of children and families. Human service professionals who want to engage service consumers as active partners in their own healing too often face institutional and bureaucratic barriers to the actions their principles may impel them to take. Professionals are also asked to commit their skills and knowledge to community-building endeavors that may at some point call into question the value of their expertise. "New partnerships are needed that blend both professional and experiential expertise, formal and informal systems of support, and public and private response."[600] Forging these partnerships is one of the foremost challenges facing professionals and the communities they serve.

To become effective partners with natural helpers within the community, public service agencies must adopt new ways of doing business. They must foster shared responsibility, enable collaborative use of available resources, redefine leadership outside of the constraints of organizational hierarchies, and welcome community leaders, parents, and youth into their policymaking circles.

To strengthen and sustain communities, professionals must believe in and foster "the inherent brilliance of people and their interdependence as part of a community."[401] Yoland Trevino describes the essence of her job as Director of the Vaughn Family Center in the San Fernando Valley of California as "unleashing human capital." She emphasizes that "communities have diamonds in the rough waiting to be discovered. Communities have leaders waiting for an opportunity. People volunteer their gifts when their gifts are recognized and valued. Leaders come in all shapes and from all walks in life. Leadership needs to be cultivated and unleashed. All interactions among people can be mutually transformative."[402]

Professionals also need to capitalize on the strengths of their formal, institutional systems and build on these assets, even as communities strive to redress the shortcomings of public service bureaucracies. In describing optimal partnerships between professionals and natural helpers, Kinney and Trent outline the strengths of professionals:[403]

- **Conceptualizing issues**: Professionals have conceptual frameworks that can be helpful in organizing information, understanding issues, and defining options.
- **Training and problem-solving**: Professionals know many ways to solve problems, and can train others in the use of these tools, techniques, and strategies.
- **Mentoring and identification of strengths**: Professionals can help community members and natural helpers recognize their strengths and encourage them to follow through with their beliefs and celebrate their successes.
- **Evaluation**: Many professionals are trained to define measurable outcomes, and to systematically collect and analyze information.
- **Fundraising and grants management**: Most professionals are able to write proposals in the language used by funding sources, and have experience in budgeting and in monitoring financial and program goals and objectives.
- **Advocacy**: Professionals can speak out in behalf of communities, families, and children, and can often translate community and neighborhood priorities and concerns to policymakers.
- **Service delivery**: Some professionals have specialized knowledge in diagnosing and meeting clinical and treatment needs of individuals and families.

Clearly, professionals have much to offer communities committed to improving the quality of life for their children and families. The key is for outside experts to do only what is necessary to support people in taking control of their own lives and contributing to their communities. In some instances, it may also be appropriate for professionals to work toward passing their roles as formal leaders and guides to those within communities.

Professionals also need to learn to take on unfamiliar new roles like those the Director of the Vaughn Family Center adopted in her work to "unleash human capital": "mentor, coach, weaver of dreams, facilitator, catalyst, nurturer, and catcher of dreams."[404] Successfully filling these roles requires a significant investment of time, untiring passion for the work, and a capacity to listen deeply and appreciatively to community members' expressions of anger and of hope. Professionals who take the risk of filling these new roles, and who recognize the assets

that community members bring to the table, will reap the rewards of being welcomed as effective partners with communities in their collective efforts to grow healthy, safe, and thriving children.

A FRAMEWORK FOR COMMUNITY ACTION

Community action encompasses a wide range of efforts to improve the quality of life for community members. Many initiatives have focused on rebuilding poor urban communities. Children of affluent communities, however, are also at risk for abuse and neglect, and have the same needs as all other children.

The Framework *Community Implementation Guide* (CIG) speaks to the tasks and challenges facing those who take on the implementation of the Framework or other comprehensive community initiatives regardless of the economic strength of the communities they serve. It presents five community action phases that represent a compilation of the rich experiences of many community-based initiatives described by diverse analysts and advocates. They incorporate the Framework's guiding principles and comprise a "framework for community action" that communities can apply in their efforts to take a comprehensive approach to meeting the universal needs of their children.

The CIG contains practical tools for each of the community action phases, information on innovative initiatives, and a thorough listing of resource organizations that provide information, technical assistance and funding.

A CALL TO ACTION

Over the last quarter century, recognition has grown that preventing children from being harmed is a better investment of societal resources than intervening after harm has been done. We also know it is essential to support and intervene in behalf of children as early as possible to promote their healthy development and ensure the safety and wellness of our communities. We have learned that our existing formal service systems cannot provide all or even most of the nurturance, education, and support that children need to become healthy, vital, contributing members of society. Communities, with their unique networks of informal and formal associations, play vital roles in addressing complex problems that neither government agencies nor the private sector can hope to resolve alone.

CWLA is committed to engaging people everywhere in meeting the five universal needs of children. The Framework *Community Implementation Guide*, the companion to this monograph, is the first in a series of resources that will provide practical guidance and tools for communities as they work to make children a priority. It synthesizes the wealth of experience and knowledge gained through many previous collaborative efforts in communities across the country and details strategies and resources for collaborative community efforts to meet children's universal needs.

Everyone who has a stake in the healthy development of children, that is, all of us, must work together as partners to protect and nurture children. We are all members of interwoven communities defined by faith, values, culture, geography and shared history. It is through our active participation in these communities that we can most effectively realize our vision of an America where all children are safe, healthy, and thriving.

Imagine that!

Endnotes

[1] Lieberman Research Worldwide. (1999, April). *Assessing public opinion and perceptions regarding child abuse in America: Final report.* Prepared for the Child Welfare League of America, Washington, DC.

[2] See the Neighborworks website: http://www.nw.org.

[3] Gershoff, E. T., Aber, J. L., & Raver, C. C. (2003). Child poverty in the U.S.: An evidence-based conceptual framework for programs and policies. In R. M. Lerner, F. Jacobs, & D. Wertlieb (Eds.), *Handbook of applied developmental science: Promoting positive child, adolescent, and family development through research, policies, and programs* (Vol. 1). Thousand Oaks, CA: Sage.

[4] See One America: The President's Initiative on Race: http://clinton4.nara.gov/Initiatives/OneAmerica/america_onrace.html

[5] Parker, S., Greer, S., and Zuckerman, B. (1988). Double jeopardy: The impact of poverty on early child development. *The Pediatric Clinics of North America, 35*(6), 1227–1240.

[6] Ibid.

[7] Ibid.

[8] Federal Interagency Forum on Child and Family Statistics. (2002). *America's children: Key national indicators of well-being, 2002.* Washington, DC: U.S. Government Printing Office.

[9] The U.S. Bureau of the Census defines poverty using a set of money income thresholds based on family size and composition. If a family's total income, before taxes, and excluding noncash benefits, such as Medicaid and Food Stamps, is less than the threshold, then all members of the family are considered poor. Using these guidelines, a family of four making less than $17,602 per year is considered poor.

[10] Federal Interagency Forum on Child and Family Statistics. (2002), op. cit.

[11] National Center for Children in Poverty. (2002). *Child poverty fact sheet.* New York: Columbia University.

[12] Federal Interagency Forum on Child and Family Statistics. (2002), op. cit.

[13] Federal Interagency Forum on Child and Family Statistics. (2002), op. cit.

[14] Hofferth, S. L. (1998). The American family: Changes and challenges for the 21st century. In H. M. Wallace (Ed.), *Health and welfare for families in the 21st century.* Sudbury, MA: Jones and Bartlett.

[15] Fraser, M. W. (1997). The ecology of childhood: A multisystems perspective. In M.W. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective.* Washington, DC: NASW Press.

[16] Fraser, M. W. (1997) The ecology of childhood: A multisystems perspective, op. cit.

[17] National Center for Children in Poverty, op. cit.

[18] Ibid, p. 15; Lalonde, R. J. (1995). The promise of public sector-sponsored training programs. *Journal of Economic Perspectives, 9,* 149–168.

[19] Heymann, S. J., & Earle, A. (1998). The work-family balance: What hurdles are parents leaving welfare likely to confront? *Journal of Policy Analysis and Management, 17,* 313–321.

[20] Gershoff, Aber, & Raver, op. cit.

[21] Gershoff, Aber, & Raver, op. cit.

[22] Office of Child Support Enforcemnt. (2001). *FY2000 Preliminary data report.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Available from http://www.acf.dhhs.gov/programs/cse/pubs/2000/datareport/.

[23] Schreiner, M., Sherraden, M., Clancy, M., Johnson, Curley, J., Grinsten-Weiss, M., et al. (2001). *Savings and asset accumulation in Individual Development Accounts: Downpayments on the American Dream Policy demonstration, a national demonstration of Individual Development Accounts.* St. Louis, MO: Center for Social Development. Available from http://gwbweb.wustl.edu/Users/csd/add/ADDreport2001/contents.html/.

[24] Ibid, p. 11.

[25] Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

[26] Morgan, B. L. G., & Winick, M. (1985). Pathologic effects of malnutrition on the central nervous system. In K. R. Gibson & A. C. Petersen (Eds.), *Brain maturation and cognitive development: Comparative and cross-cultural perspectives*. New York: Aldine de Gruyter.

[27] Story, M., & Harnack, L. (1999) Nutrition issues for mothers, children, youth, and families. In H. M. Wallace (Ed.), *Health and welfare for families in the 21st century*. Sudbury, MA: Jones and Bartlett.

[28] HHS. *Healthy People 2000*.

[29] Federal Interagency Forum on Child and Family Statistics, op. cit.

[30] Federal Interagency Forum on Child and Family Statistics, op. cit.

[31] Ibid.

[32] Life Sciences Research Office and American Institute of Nutrition. (1990). *Core indicators of nutritional state for difficult to sample populations*. Bethesda, MD: Author.

[33] Ibid.

[34] Federal Interagency Forum on Child and Family Statistics. (2002), op. cit.

[35] Federal Interagency Forum on Child and Family Statistics. (2002), op. cit. p. 21.

[36] Ibid.

[37] Gershoff, Aber, & Raver, op. cit. p. 20.

[38] National Association of WIC Directors. *WIC–Building a healthier future for America's children: Fact sheet*.

[39] Gershoff, Aber, & Raver, op. cit. p. 20.

[40] Gershoff, Aber, & Raver, op. cit. p. 20.

[41] Nutrition–Cognition National Advisory Committee. (1998). Statement on the link between nutrition and cognitive development in children. Boston: Center on Hunger, Poverty, and Nutrition Policy, Tufts University School of Nutrition Science and Policy. Available from http://hunger.tufts.edu/pub/statement.shtml

[42] Ibid, p. 20.

[43] America's Second Harvest. *Hunger in America 2001*. Chicago: Author. Available from www.secondharvest.org.

[44] Ibid.

[45] Kaufman, T. (1996). *Housing America's future: Children at risk*. Washington, DC: National Low Income Housing Coalition.

[46] Ibid.

[47] Weinreb, L., Goldberg, R., Bassuk, E., & Perloff, J. (1998). Determinants of health and service use patterns in homeless and low-income housed children. *Pediatrics, 102*, 554–562.

[48] Sherman, P., & Redlener, I. (1999). Homeless women and their children. In H. M. Wallace (Ed.), *Health and welfare for families in the 21st century*. Sudbury, MA: Jones and Bartlett.

[49] Federal Interagency Forum on Child and Family Statistics. (2002), op. cit. p. 19.

[50] National Housing Coalition. (1999). *Out of reach: The gap between housing costs and income of poor people in the United States*. Washington, DC: Author.

[51] Ibid.

[52] National Coalition for the Homeless. (1999, June). *Homeless families with children: NCH Fact Sheet #7*. Washington, DC: Author.

[53] Child Welfare League of America. (2000). Housing and homelessness: Housing solutions for child welfare families. Washington, DC: Author. Available from http://www.cwla.org/programs/housing/.

[54] Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). *Homelessness: Programs and the people they serve: Summary report–Findings of the National Survey of Homeless Assistance Providers and Clients*. Washington, DC: Urban Institute. Available from http://www.urban.org/housing/homeless/homeless/html.

[55] Ibid.

[56] Vissing, Y. (1996). Out of sight, out of mind; Homeless children and families in small town America, 1996. Lexington, KY: University Press of Kentucky.

[57] U. S. Conference of Mayors. (2000). *A status report on hunger and homelessness in America's cities.* Washington, DC: Author.

[58] Pew Partnership. *Thriving neighborhoods. Affordable housing.* Available from www.pew-partnership.org.

[59] Lindblom, E. N. (1991). Toward a comprehensive homelessness prevention strategy. *Housing Policy Debate, 2*(3), 957–1094.

[60] Pew Partnership. *Thriving neighborhoods. Affordable housing.* Available from www.pew-partnership.org.

[61] Gershoff, Aber, & Raver, op. cit. p. 23.

[62] Gershoff, Aber, & Raver, op. cit. p. 23

[63] Neighborhood Reinvestment Corporation. (1996). *Winning strategies: Best practices in the work of home ownership production.* Washington, DC: Author.

[64] Applied Real Estate Analysis (AREA), Inc. (1998). *Making home ownership a reality: Survey of Habitat for Humanity (HFHI), Inc. homeowners and affiliates.* Washington, DC: U.S. Department of Housing and Urban Development.

[65] Rohe, W. M., Roberto, G. Q, Levy, D. K, & Biswas, P. (1998). *Sustainable nonprofit housing development: An analysis of the Maxwell Award winners.* Washington, DC: Fannie Mae Foundation.

[66] McCamant, K. M. (2002). *Cohousing communities: A model for reinvigorating urban neighborhoods.* Available from www.newvillage.net/1urbaninfill.html.

[67] Hack, M., Klein, N. K., & Taylor, H. G. (1995). Long-term developmental outcomes of low birth weight infants. *Future of Children, 5*(1).

[68] Institute of Medicine, Committee to Study the Prevention of Low Birth Weight. (1985). *Preventing low birth weight.* Washington, DC: National Academy Press.

[69] Martin, J. A., Hamilton, B. E., Ventura, S. J., Menacker, F., & Park, M. M. (2002). Births: Final data for 2000. *National Vital Statistics Reports, 50*(5). Hyattsville, MD: National Center for Health Statistics.

[70] Federal Interagency Forum on Child and Family Statistics, op. cit.

[71] Martin, J. A., Hamilton, B. E., Ventura, S. J., Menacker, F., Park, M. M., & Sutton, P. D. (2002). Births: Final data for 2001. *National Vital Statistics Reports, 51*(2), Tables 24, 25, and 33. http://www.cdc.gov/nchs/data/nvsr/nvsr51_02.pdf.

[72] Ibid.

[73] Maynard, R. A. (Ed.). (1996). *Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing.* New York, NY: The Robin Hood Foundation.

[74] Centers for Disease Control and Prevention, National Center for Health Statistics. (2002). *Teenage births in the United States. State trends 1991–2000: An update.* Atlanta, GA: Centers for Disease Control and Prevention.

[75] Ibid.

[76] National Campaign to Prevent Teen Pregnancy. (1997). *Whatever happened to childhood? The problem of teen pregnancy in the United States.* Washington, DC: Author; Alan Guttmacher Institute. (1994). *Sex and America's teenagers* (p. 76). New York: Author.

[77] Centers for Disease Control and Prevention. (2002) op. cit.

[78] Federal Interagency Forum on Child and Family Statistics, op. cit. p. 30.

[79] Ibid.

[80] Devaney, B., Howell, E. M., McCormick, M., & Moreno, L. (2000, July). *Reducing infant mortality: Lessons learned from Healthy Start.* Final Report, Princeton, NJ: Mathematica Policy Research, Inc. See also www.healthystartassoc.org.

[81] Grason, H., & Morreale, M. (1997). Health services for children and adolescents: A "non-system" of care. In R. E. K. Stein (Ed.), *Health care for children: What's right, what's wrong.* New York: United Hospital Fund.

[82] Federal Interagency Forum on Child and Family Statistics, op. cit.

[83] Ibid.

[84] Center for Mental Health Services. (2002). Children's and adolescents' mental health. Washington, DC: U.S. Department of Health and Human Services, National Mental Health Information Center. Available from http://www.samhsa.gov/centers/clearinghouse/clearinghouses.html.

[85] Federation of Families for Children's Mental Health. (2002). About our children. www.ffcmh.org/Eng_one.htm.

[86] Ibid.

[87] Center for Mental Health Services. (2002), op. cit.

[88] Federation of Families for Children's Mental Health. (2002), op. cit.

[89] Cleaver, H. (2002). Behavior problems common in kids with ill siblings. Available from http://www.vaccinationnews.com/DailyNews/October2002/BehaviorProblems10.htm.

[90] CPS Annual Demographic Survey, March Supplement. Available from www.ferret.bls.census.gov/macro/032002/health/h08_000.htm

[91] The Kaiser Commission on Medicaid and the Uninsured. (1998). *Uninsured in America: A chart book*. Washington, DC: Author.

[92] U.S. Bureau of the Census. (2002). CPS Annual Demographic Survey, March supplement. Washington, DC: Bureau of Labor Statistics. Available from http://www.ferret.bls.census.gov/macro/032002/health/h08_000.htm.

[93] Gershoff, Aber, & Raver, op. cit. p. 21.

[94] Gershoff, Aber, & Raver, op. cit. p. 21.

[95] Hawkins, J. D., & Wall, J. S. (1980). *Alternative education: Exploring the delinquency prevention potential* (Reports of the National Juvenile Justice Assessment Centers (GPO #1980-0311-379 1398). Washington, DC: U.S. Government Printing Office.

[96] Ibid.

[97] Editorial Projects in Education, Inc. (1999). *Quality counts 1999: Public agenda: Reality check*. Bethesda, MD: Author.

[98] Federal Interagency Forum on Child and Family Statistics, op. cit. p 51.

[99] Falbo, T., & Glover, R. W. (1999). Promoting excellence in American adolescents. In A.J. Reynold, H. J. Walberg, & R. P. Weissberg (Eds.), *Promoting positive outcomes: Issues in children's lives and families lives*. Washington, DC: CWLA Press.

[100] Ibid.

[101] Mullis, I. (1998). *Mathematics and science achievement in the final year of secondary school: IEA's Third International Mathematics and Science Study*. Chestnut Hill, MA: Boston College.

[102] National Black Caucus of State Legislators, Committee on Elementary and Secondary Education. (2001, November). *Closing the achievement gap. Improving educational outcomes for African American children.*

[103] Christian, D. (1994). *Two-way bilingual education: Students learning through two languages. Educational Practice Report 12*. Santa Cruz, CA, and Washington, DC: National Center for Research on Cultural Diversity and Second Language Learning.

[104] Coalition for Community Schools. Available from www.communityschools.org/partnerships.html.

[105] Ibid.

[106] Grossman, J. B. (Ed.). (1999). *Contemporary issues in mentoring* (pp. 17-22). Philadelphia: Public/Private Ventures.

[107] Kotlarczyk, C. (1997). *High yield bonds: How to keep kids invested in school*. Geneseo, NY: Clarion.

[108] National Research Council and Institute of Medicine, op. cit. p. 27.

[109] Weissbord, B. (2001). Motherhood. In J.C. Westman (Ed.), *Parenthood in America: Undervalued, underpaid, under siege*. Madison, WI: University of Wisconsin Press.

[110] Federal Interagency Forum on Child and Family Statistics, op. cit.

[111] Bornstein, M. H. (2001). Refocusing on parenthood. In J.C. Westman (Ed.), *Parenthood in America: Undervalued, underpaid, under siege*. Madison, WI: University of Wisconsin Press.

[112] Bowlby, J. (1973). Attachment and loss (Vol. 2: Separation). New York: Basic Books.

[113] Easterbrooks, M. A., & Goldberg, W. A. (1990). Security of toddler-parent attachment: Relationship to children's sociopersonality functioning during kindergarten. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years* (pp. 221–224). Chicago: University of Chicago Press.

[114] National Research Council and Institute of Medicine, op. cit. p. 233.

[115] Weinreb, M. L. (1997). Be a resiliency mentor: You may be a lifesaver for a high-risk child. *Young Children, 52*(2), 14–20.

[116] Barnes, G. M., & Farrell, M. P. (1992). Parental support and control as predictors of adolescent drinking, delinquency, and other behavior problems. *Journal of Marriage and the Family, 54*, 763–776.

[117] Ibid.

[118] Ibid.

[119] Hart, P. D. (1997). *Zero to three: Key findings for a nationwide survey among parents of zero-to-three year olds.* Baltimore, MD: National Center for Infants Toddlers and Families.

[120] Shreve, A. (1987). *Remaking motherhood: The consequences of an ideal* (p. 18). New York: Shocken.

[121] Hart, P. D. (1997), op. cit.

[122] Bumpass, L. (2001). The changing contexts of parenting in the United States. In J. C. Westman (Ed.), *Parenthood in America: Undervalued, underpaid, under siege.* Madison, WI: University of Wisconsin Press.

[123] Wallerstein, J. S. (2001). The challenge of divorce for parents and children. In J. C. Westman (Ed.), *Parenthood in America: Undervalued, underpaid, under siege.* Madison, WI: University of Wisconsin Press.

[124] Ibid.

[125] Ibid.

[126] Ibid.

[127] Manning, W. D. (2001, June). The complexity of fathers' parenting responsibilities and involvement with non-resident children. In *Population Studies Center Research Report 01-478.* Ann Arbor, MI: University of Michigan. Available from www.psc.isr.umich.edu .

[128] Ibid.

[129] Amato, P. R., & Keith, B. (1991). Parental divorce and the well-being of children: A meta-analysis. *Psychological Bulletin, 110*, 26–46.

[130] Hughes, R., Jr. (1992). *The effects of divorce on children.* Department of Family Relations and Human Development, The Ohio State University.

[131] Weissbord, B. (2001) Motherhood. In J. C. Westman (Ed.), *Parenthood in America: Undervalued, underpaid, under siege.* Madison, WI: University of Wisconsin Press.

[132] U.S. Department of Health and Human Services, Administration for Children and Families, Adoption and Foster Care Analysis and Reporting System (AFCARS). Available from www.acf.dhhs.gov/programs/cb/dis/ afcars/index.html

[133] Maza, P. L. (2002, November). *Is the Adoption and Safe Families Act doing what it is supposed to do?* Presentation at Lifetime Connections: Achieving Excellence in Adoption, Child Welfare League of America.

[134] Ibid.

[135] Tracy, E. M. (2000). What works in family support programs. In M. P. Kluger, G. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 3–9). Washington, DC: CWLA Press.

[136] Brodzinksy, D. (1993). Long-term outcomes in adoption. *Future of Children, 3*(1), 154–166.

[137] Ibid.

[138] Barth, R. P., & Berry, M. (1988). *Adoption and disruption: Rates, risks and resources.* New York: Aldine.

[139] Howard, J. A., & Smith, S. L. (1995). *Adoption preservation in Illinois: Results of a four-year study.* Normal, IL: University of Illinois State University School of Social Work.

[140] National Research Council and Institute of Medicine, op. cit. p. 234.

[141] Dunn, J., & Munn, P. (1986). Siblings and the development of prosocial behavior. *International Journal of Behavioral Development, 23*, 791–798.

[142] Child Trends. (2000, May). *Preventing problems vs. promoting the positive: What do we want for our children?* (Research brief). Washington, DC: Author.

[143] Simmons, T., & O'Neil, G. (2001). Households and families: 2000. *Census 2000 Brief. U.S. Census Bureau.* Washington, DC: U.S. Government Printing Office.

[144] Child Welfare Research Center. (2002). *Child welfare supervised foster care supplementary reports: Sibling tables.* Berkeley, CA: University of California, Berkeley. Available from http://cssr.berkeley.edu/CWSCMSreports.

[145] New York City Administration for Children's Services. (2000). *First annual placement report* (pp. 16–19). Available from http://www.ci.nyc.ny.us/html/acs/html/whatwedo/first_annual-placement.html.

[146] Berrick, J. D., Barth, R. P., & Needell, B. (1994). A comparison of kinship foster homes and foster family homes: Implications for kinship foster care as family preservation. *Children and Youth Services Review, 16,* 323–63.

[147] Berrick, J. D., Needell, B., Barth, R. P., & Johnson-Reid, M. (1998). *The tender years.* New York: Oxford University Press.

[148] Ibid.

[149] Casey Family Programs. National Center for Resource Family Support. *Ideas on siblings in out of home care.* Available from www.casey.org/cnc/policy_issues/ideas_on_siblings.htm.

[150] Edgewood Center for Children and Families. (2001). *Fact sheet #5: What policymakers can do to support kin caregivers.* Available from www.edgewoodcenter.org/results/stuartfactsheets.htm.

[151] Parker, J. G., & Asher, S. R. (1987). Peer relations and later personal adjustment: Are low-accepted children at risk? *Psychological Bulletin, 102,* 357–389.

[152] Roehlkepartain, E. C. (1992, March). What teens need from adults. *RespecTeen Newsletter.* Available from http://www.search-institute.org/archives/wtnfa.htm.

[153] Barlow, Z. (2002, March). Thinking outside the classroom: An interview with Zenobia Barlow. *The Sun, 315,* 4–11.

[154] Wells, C. G. (1985). Preschool literacy-related activities and success in school. In D. Olson, N. Torrance, & A. Hildyard (Eds.), *Literacy, language, and learning: The nature and consequences of literacy* (pp. 229–255). Cambridge, UK: Cambridge University Press.

[155] U.S. Department of Health and Human Services, National Institute of Child Health and Human Development. (1998). *The NICHD study of early child care.* Washington, DC: Author.

[156] National Research Council and Institute of Medicine, op. cit. p. 235.

[157] Ramey, C. T., & Campbell, F. A. (1984). Preventive education for high-risk children: Cognitive consequences of the Carolina Abecedarian Project. *American Journal of Mental Deficiency, 88,* 515–523.

[158] Currie, J. (2000). *Early childhood intervention programs: What do we know?* (JCPR Working Paper Series). Arlington, VA: National Science Foundation.

[159] Karoly, L. A., Greenwood, P. W., Everingham, S. S., Houbé, J., Kilburn, M. R., Rydell, C. P., et al. (1998). *Investing in our children: What we know and don't know about the costs and benefits of early childhood interventions* (MR-898-TCWF). Santa Monica, CA: RAND.

[160] Chandler, K., Nord, C. W., Lennon, J., & Liu, B. (1999). *Statistics in brief: Home literacy activities & signs of children's emerging literacy, 1993 and 1999.* Washington, DC: National Center for Education Statistics. Based on the National Household Education Survey, 1993 and 1999 analysis. Available from nces.ed.gov/pubsearch/pubinfo.asp?pubid=2000026.

[161] Ibid.

[162] Ibid.

[163] Federal Interagency Forum on Child and Family Statistics. (2002), op. cit. p. 48.

[164] National Institute of Child Health & Human Development. (1999). *NICHD child care study investigators to report on child care higher quality care related to less problem behavior* (NIH News Alert). Washington, DC: U.S. Department of Health and Human Services. Available from www.nichd.nih.gov/new/releases/DAYCAR99.cfm.

[165] Kontos, S., Howes, C., Shinn, M., & Galinsky, E. (1994). *Quality in family child care and relative care.* New York: Families and Work Institute.

[166] Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Culkin, M. L., Howes, C., Kagan, S. L., et al. (1999). *The children of the Cost, Quality, and Child Outcomes Study go to school: Executive summary.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Center. Available from http://www.fpg.unc.edu/~ncedl/PDFs/CQO-es.pdf.

[167] Burchinal, M. R., & Nelson, L. (2000). Family selection and child care experiences: Implications for studies of child outcomes. *Early Childhood Research Quarterly, 15*, 385–411.

[168] National Institute of Child Health & Human Development. (1999), op. cit.

[169] Center for the Child Care Workforce. (1990). Who cares? Child care teachers and the quality of care in America. Washington, DC: Author.

[170] Peisner-Feinberg, Burchinal, Clifford, Bulkin, Howes, Kagan, et al. (1999), op. cit.

[171] ---. (1996). *Learning from others: Good programs and successful campaigns.* Academy for Education Development and Center for Law and Education.

[172] Karoly, Greenwood, Everingham, Houbé, Kilburn, Rydell, et al. (1998), op. cit.

[173] Ramey & Campbell. (1984), op. cit.

[174] Pew Partnership for Civic Change. (2001). *Wanted: Solutions for America. What we know works.* Charlottesville, VA: Pew Partnership. Available from http://www.pew-partnership.org/familieschildren/youthdev/afterschool.html.

[175] Federal Interagency Forum, op. cit. Figure POP7.C.

[176] Ibid.

[177] Ibid.

[178] Ibid.

[179] Ibid.

[180] Ibid.

[181] Children's Aid Society. (2002). *Fact sheet on afterschool programs.* New York: Author. Available from http://www.childrensaidsociety.org/media/general/Factsheetafterschool.pdf.

[182] Lake, Snell, Perry, & The Associates, and the Tarrance Group. (2001). *Afterschool alliance poll.* Washington, DC: Afterschool Alliance. Available from http://www.afterschoolalliance.org/after_over.cfm.

[183] The Search Institute. (2002). *Developmental assets: An overview.* Available from www.search-institute.org.

[184] The Search Institute, op. cit.

[185] U.S. Department of Education. (2000). *21st-century community learning centers: Providing quality afterschool learning opportunities for America's families.* Available from www.ed.gov/pubs or call 800/USA-LEARN.

[186] Policy Studies Associates, Inc. (2001, February). *Building quality and supporting expansion of afterschool projects: Evaluation Results from the TASC Afterschool Program's second year.* Washington, DC: Author.

[187] Beckett, M., Hawken, A., & Jacknowitz, A. (2001). Accountability for after-school care: Devising standards and measuring adherence to them. Santa Monica, CA: RAND. Available from www.rand.org/publications/RB?RB2505.

[188] Lake, Snell, Perry, & Associates, and the Tarrance Group. (2001), op. cit.

[189] David and Lucile Packard Foundation. (2002). Poll of public views on welfare reform and children in the current economy. Available from www.afterschoolalliance.org/after_over.cfm.

[190] Lerner, R. M., Fisher, C. B., & Weinberg, R. A. (2000). Toward a science for and of the people: Promoting civil society through the application of developmental science. *Child Development, 71*, 11–20. As cited in Roth, J., & Brooks-Gunn, J. (2000). What do adolescents need for healthy development? Implications for youth policy. *SRCD Social Policy Report, 14*(1).

[191] Child Welfare League of America. (in press). *Foster youth involvement toolkit.* Washington, DC: CWLA Press.

[192] McLaughlin, M. W. (2000). *Community counts: How community organizations matter for youth development.* Washington, DC: Public Education Network.

[193] Morgan, W., & Streb, M. (2001). *The impact of service-learning on political participation.* Available from http://pro.harvard.edu/papers/037/037008MorganWill.pdf.

[194] National Commission on Service Learning. (2001). *The power of service-learning for American schools.* Available from www.servicelearningcommission.org/report.html.

[195] National Center on Addiction and Substance Abuse at Columbia University. (2001). *So help me God: Substance abuse, religion, and spirituality* (pp. 8–12). New York: Columbia University. Available from http://www.casacolumbia.org/publications1456/publications_show.htm?doc_id=91513.

[196] Smith, C., & Faris, R. (2002). *Religion and American adolescent delinquency, risk behaviors and constructive social activities.* Chapel Hill, NC: National Study of Youth and Religion. Available from www.youthandreligion.org/publications/docs/RiskReport1.pdf.

[197] Monitoring the Future Survey. (2002). Available from www.monitoringthefuture.org.

[198] Ibid.

[199] Ibid.

[200] Benson, P. L., & Saito, R. (2000). The scientific foundations of youth development. In *Youth development: Issues, challenges, and directions.* Philadelphia: Public/Private Ventures.

[201] Ibid.

[202] Ibid.

[203] Monitoring the Future Survey, op. cit.

[204] Casey Family Programs. (2001). *It's my life: Summary of a framework for youth transitioning from foster care to successful adulthood.* Seattle, WA: Casey Family Programs.

[205] Child Welfare League of America. (in press). *Foster youth involvement toolkit.* Washington, DC: CWLA Press.

[206] Adapted from materials developed by the Center for Youth Development and Policy Reserarch, Washington, DC.

[207] Pittman, K., Irby, M., & Ferber, T. (2000). Unfinished business: Further reflections on a decade of promoting youth development. In *Youth development: Issues, challenges, and directions.* Philadelphia: Public/Private Ventures.

[208] Pittman, K. (2001, March 21). What fills the empty space? Facing challenges in the out-of-school hours. Paper presented at Solving the Equation: Do the Math Part II, Suffern, NY.

[209] Center for Early Adolescence, University of North Carolina. (2000). *Living with 10-15 year-olds: A parent education curriculum.* Chapel Hill, NC: University of North Carolina.

[210] Printz, T. J. (1998). *Faith based service providers in the nation's capital: Can they do more?* Available from www.urban.org/template.cfm?Template=/TaggedContent/ViewPublication.cfm&PublicationID=5935&NavMenuID=95

[211] Ibid.

[212] White, A. (2000). Citizen power for stronger families: Community partnerships for protecting children, Jacksonville, FL. New York: The Edna McConnell Clark Foundation.

[213] Child abuse and neglect are defined in federal and state statutes. CWLA standards provide the following generally accepted definitions:

- *Physical abuse* is nonaccidental physical acts by parents or caregivers that cause, or could have caused, physical injury to the child.
- *Neglect* is the failure of parents or other caregivers, for reasons not solely due to poverty, to provide the child with needed, age-appropriate care, including food, clothing, shelter, protection from harm, supervision appropriate to the child's development, hygiene, education and medical care.
- *Sexual abuse* is sexual activity by a parent or other caregiver with a child including, but not limited to, any kind of sexual contact through persuasion, physical force, or other coercive means; exploitation through sexual activity that is allowed, encouraged, or coerced; and child prostitution or pornography.
- *Emotional maltreatment* is acts or omissions by a parent or other caregiver, such as rejecting, terrorizing, berating, ignoring or isolating a child, that cause, or are likely to cause, the child serious impairment of their physical, social, mental, or emotional capacities.

Child Welfare League of America. (1998). CWLA standards for services for abused or neglected children and their families. Washington, DC: Author.

[214] National Clearinghouse on Child Abuse and Neglect Information. (2001, October). *Understanding the effects of maltreatment on early brain development.* Available from www.calib.com/nccanch/pubs/focus/earlybrain.cfm.

[215] Perry, B. D. (2001). Understanding the effects of maltreatment on early brain development. Available from http://www.calib.com/nccanch/pubs/focus/earlybrain.cfm.

[216] Widom, C. S., & Maxfield, M. (2001, March). Research in brief: An update on the "cycle of violence." Washington, DC: National Institute of Justice.

[217] Jaffe, P., & Sudermann, M. (1995). Child witness of women abuse: Research and community responses. In S. Stith & M. Straus (Eds.), *Understanding partner violence: Prevalence, causes, consequences, and solutions. Families in focus series, Vol. II.* Minneapolis, MN: National Council on Family Relations.

[218] Family Violence Prevention Fund. *Fact sheet: Children and domestic violence.* Available from http://endabuse.org/programs/display.php3?DocID=77.

[219] Jaffe, P., Hurley, D., & Wolfe, D. 1990. Children's observations of violence: I. Critical issues in child development and intervention planning. *Canadian Journal of Psychiatry, 35*, 466–470.

[220] Moreley, E. (1997, March). Presentation at Portland State University Conference on Children of Domestic Violence.

[221] Maryland Domestic Violence Coalition. (1994). *Broken bodies, broken spirits: Family violence in Maryland and recommendations for change.*

[222] Child protective services usually handles allegations of child abuse or neglect by parents or other caregivers. Law enforcement handles allegations of criminal acts against children by any adult or juvenile. Thus, some incidents of physical or sexual abuse of children by parents and other caregivers will also be included in the reports of violent crime against children cited later in this chapter.

[223] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2002). *Child maltreatment 2000.* Washington, DC: U.S. Government Printing Office.

[224] Ibid.

[225] Ibid.

[226] Combs-Orme, T., Martin, L., Litten Fox, G., Faver, C. A. (2000). Risk for child maltreatment: New mothers' concerns and screening test results. *Children and Youth Services Review, 22*, 517–537.

[227] Carter L. S., Weithorn, L. A., & Behrman, R. E. (1999). Domestic violence and children: Analysis and recommendations. *Future of Children, 9*(3), 4–20.

[228] McKay, M. M. (1994). The link between domestic violence and child abuse: Assessment and treatment considerations. *Child Welfare, 73*, 29–39.

[229] U.S. Advisory Board on Child Abuse and Neglect. (1995). *A nation's shame: Fatal child abuse in the United States. A report of the U.S. Advisory Board on Child Abuse and Neglect.* Washington, DC: U.S. Department of Health and Human Services.

[230] Berry, F. (1994). A neighborhood based approach: What is it? In G. Melton & F. Berry (Eds.), Protecting children from abuse and neglect: Foundations for a new strategy (p. 14–39). New York: Guilford.

[231] Brooks-Gunn, J., Duncan, G. J., Aber, J. L. (1997). *Neighborhood poverty: Vol. 2: Policy implications in studying neighborhoods.* New York: Russell Sage.

[232] Olds, D., Eckenrode, J., Henderson, C. R., Jr., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long term effects of home visiting on maternal life course and child abuse and neglect: 15-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*, 637–643.

[233] Olds, D. op cit.

[234] Caldwell, R. A. (1992). *The costs of child abuse vs. child abuse prevention: Michigan's experience.* Lansing, MI: Michigan's Children's Trust Fund. Available from www.msu.edu/user/bob/cost.html.

[235] National Respite Coalition Testimony submitted to the Subcommittee on Select Education, the Committee on Education and the Workforce, U.S. House of Representatives for Hearing on CAPTA: Success and failures at preventing child abuse and neglect, August 2, 2001.

[236] Ibid.

[237] Ibid.

[238] Ibid.

[239] Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy.* Washington, DC: CWLA Press.

[240] Ibid.

[241] Groves, B.M. (2002). *Children who see too much: Lessons from the child witness to violence program.* Boston: Beacon Press.

[242] Bureau of Justice Statistics. (2001). *Criminal victimization 2000: Changes 1999–2000, with Trends 1993–2000.* Available from www.ojp.usdoj.gov/bjs.

[243] Finkelhor, D., & Ormrod, R. (1998). *OJJDP bulletin*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

[244] Ericson, N. (2001, June). *Addressing the problem of juvenile bullying. OJJDP fact sheet #27*. Washington, DC: U.S. Department of Justice.

[245] Ibid.

[246] Schwab-Stone, M., Chen, C., Greenberger, E., Silver, D., Lichtman, J., & Voyce, C. (1999). No safe haven II: The effects of violence exposure on urban youth. *American Academy of Child and Adolescent Psychiatry, 38*, 359–367.

[247] Kliewer, W., Lepore, S., Oskin, D., & Johnson, P. (1998). The role of social and cognitive processes in children's adjustment to community violence. *Journal of Consulting and Clinical Psychology, 66*, 199–209.

[248] Centers for Disease Control and Prevention. (1999). *Youth risk behavior surveillance system (YRBSS)*. Atlanta, GA: Author.

[249] American Association of University Women Educational Foundation. (2001).

[250] Kaiser Family Foundation. (2001). *Talking with kids about tough issues*.

[251] Ibid.

[252] American Association of University Women Educational Foundation. (2001). *Hostile hallways: Bullying, teasing, and sexual harassment in school*.

[253] Finkelhor, D., & Ormrod, R. (1998). *OJJDP Bulletin*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

[254] Bureau of Justice Statistics. (2001), op. cit.

[255] Bureau of Justice Statistics. (2001), op. cit.

[256] Web-based Injury Statistics Query and Reporting System (WISQARS™). National estimates are based on emergency department visits. Available from www.cdc.gov/ncipc/wisqars.

[257] Silverman, J. G. (2001, August 1). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association, 286*, 572–579.

[258] Ibid.

[259] Snyder, H., & Sickmund, M. (1999, September). *Juvenile offenders and victims: 1999 national report* (NCJ 178257). Washington, DC: OJJDP National Center for Juvenile Justice.

[260] Ibid.

[261] Centers for Disease Control and Prevention. (1999). *Youth Risk Behavior Surveillance System (YRBSS)*. (1999), op. cit.

[262] Mace, P. G. (2000). What works in prevention of child sexual abuse: Child-focused prevention techniques. In M. P. Kluger, G. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 75–85). Washington, DC: CWLA Press.

[263] Ibid.

[264] Safe and Smart. (2001). In Pew Partnership for Civic Change, Wanted: Solutions for America, *What we know works*. Available from http://www.pew-partnership.org/familieschildren/youthdev/afterschool.html.

[265] Fox, J. A., & Newman, S. A., (1997). *After-school crime or after school programs: Report to the U.S. Attorney General*. Washington, DC: Fight Crime: Invest in Kids.

[266] Hawkins, J. D., Todd, I., Herrenkohl, D. P. Farrington, D. B., Catalano, R. F., Harachi, T. W., et al. (2000, April). *Predictors of youth violence*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention. Available from www.ncjrs.org/pdffiles1/ojjdp/179065.pdf.

[267] Berry, F. (2002). Child abuse prevention: Accomplishments and challenges. In J. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. Reid (Eds.), *APSAC handbook on child maltreatment* (2nd ed.). Thousand Oaks, CA: Sage.

[268] Dusenbury, L. (1997). Nine critical elements of promising violence prevention. *Journal of School Health, 67*(10), 409.

[269] The American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, the American Medical Association, the American Academy of Family Physicians, and the American Psychiatric Association.

[270] *Joint statement on the Impact of Entertainment Violence on Children. Congressional Public Health Summit* (2000, July 26). Available from www.aap.org/advocacy/releases/jstmteuc.htm.

[271] Anderson, C. A., & Bushman, B. J. (2002, March). The effects of media violence on society. *Science, 295*, 2377.

[272] American Academy of Child and Adolescent Psychiatry. Available from www.aacap.org/publications/factsfam/violence.htm.

[273] Grossman, D. (1993). On killing: The psychological cost of learning to kill in war and society. Boston: Back Bay Books.

[274] Ibid.

[275] Martin, T. (1997) *Family violence in America: Breaking the cycle for children who witness violence.* Recommendations from the 1997 Summit of the International Association of Chiefs of Police, Alexandria, VA.

[276] Center for Media Education, Washington, DC. Available from www.cme.org/children/kids.

[277] Finkelhor, D., Mitchell, K. J., & Wolak, J. (2000). *Online victimization: A report on the nation's youth.* Washington, DC: National Center for Missing & Exploited Children.

[278] Ibid.

[279] Anderson, C. A., & Bushman, B. J. (2002). *Annual Review of Psychology, 53*, 27–51.

[280] See www.csulb.edu/~rmhoppes/childvlnc.html#v-chip.

[281] American Psychological Association and the American Academy of Pediatrics. (1998). *What parents can do about TV.* Available from http://www.aap.org/advocacy/childhealthmonth/tv%2D2.htm.

[282] National Center for Missing and Exploited Children. See www.missingkids.com.

[283] McLaughlin, Brilliant, and Lang. (1998). National bias crimes training. In *Hate crimes in America*. Alexandria, VA: International Association of Chiefs of Police.

[284] Kaiser Family Foundation. (2001). Talking with kids about tough issues. Menlo Park, CA: Author.

[285] Federal Bureau of Investigation. (2000). *Uniform crime reports: Hate crime statistics.* Available from http://www.fbi.gov/ucr/cius_00/hate00.pdf.

[286] Ibid.

[287] Building Blocks for Youth. (2000). *And justice for some.* Racine, WI: National Council on Crime and Delinquency. Available from http://www.buildingblocksforyouth.org/justiceforsome/jfs.pdf.

[288] Ibid.

[289] Lambda Legal Defense and Education Fund. (2001). *Youth at the margins.* New York: Author.

[290] Bochenek, M., & Brown, A. W. (2001). *Hatred in the hallways: Violence and discrimination against lesbian, gay, bisexual, and transgender students in U.S. schools.* New York: Human Rights Watch.

[291] Gay, Lesbian, and Straight Education Network. (2001, August 7). *Press release.* Available from http://www.glsen.org.

[292] Gay, Lesbian, and Straight Education Network. (2002). *State of the states 2002: GLSEN's policy analysis of lesbian, gay, bisexual and transgender (LGBT) safer schools issues.* Washington, DC: Author. Available from http://www.glsen.org.

[293] Remignanti, A. (1996). Racism and anxiety: Talk to kids about unity. In N. Rutstein & M. Morgan (Eds.), *Healing racism: Education's role.* Springfield, MA: Witcomb.

[294] *Ten ways to fight hate: A community response guide.* Available from www.splcenter.org/teachingtolerance/tt-index.html.

[295] Blackwell, A. G., Kwoh, S., & Pastor, M. (2002). *Searching for the uncommon common ground: New dimensions on race in America.* New York: WW. Norton.

[296] Blackwell, Kwoh, & Pastor. (2002), op. cit.

[297] Centers for Disease Control and Prevention. (n.d.). *WISQARS Web-based Injury Statistics Query and Reporting System.* Available from www.cdc.gov/ncipc/wisqars. National estimates are based on emergency department visits.

[298] Centers for Disease Control and Prevention. (n.d.). op. cit.

[299] Hingson, R., & Howland, J. (1993). Promoting safety in adolescents. In S. G. Millstein, A. C. Petersen, & E. O. Nightingale (Eds.), *Promoting the health of adolescents: New directions for the twenty first century* (pp. 310–312). New York: Oxford University Press.

[500] Cerrelli, E. C. (1998). *Crash data and rates for age-sex groups of drivers, 1996. Research note. U.S. Department of Transportation.* Washington, DC: National Highway Traffic Safety Administration.

[501] National Center for Chronic Disease Prevention and Health Promotion, Youth Risk Behavior Surveillance System. See http://apps.nccd.cdc.gov/YRBSS/.

[502] The Injury Free Coalition for Kids. See www.injuryfree.org/.

[503] Centers for Disease Control and Prevention. (n.d.). op. cit.

[504] National Fire Prevention Association. *Fact sheet on home fires.* See www.nfpa.org.

[505] Centers for Disease Control and Prevention. (n.d.). op. cit.

[506] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (n.d.). Available from http://www.cdc.gov/ncipc/factsheets/fire.htm.

[507] Centers for Disease Control and Prevention. (n.d.), op. cit.

[508] Centers for Disease Control and Prevention. (n.d.), op. cit.

[509] Sosin, D. M., Sacks, J. J., & Webb, K. W. (1996). Pediatric head injuries and deaths from bicycling in the United States. *Pediatrics, 98,* 868–870.

[510] United States Maternal and Child Health Bureau, National Highway Traffic Safety Administration. (1997). *Child & adolescent emergency department visit databook.* Pittsburgh, PA: Allegheny University of the Health Sciences.

[511] Centers for Disease Control and Prevention. (n.d.), op. cit.

[512] Centers for Disease Control and Prevention. (n.d.), op. cit.

[513] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (n.d.) Available from http://www.cdc.gov/ncipc/duip/spotlite/childseat.htm.

[514] National Highway Traffic Safety Administration. (1999). *Traffic safety facts 1998: Alcohol.* Washington, DC: U.S. Department of Transportation.

[515] Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy.* Washington, DC: CWLA Press.

[516] Klassen, T. P., Morag, J., MacKay, D., Moher, A. W., & Jones, A. (2000). Community-based injury prevention interventions. *Future of Children, 10,* 1. Available from http://www.futureofchildren.org/information2826/information_show.htm?doc_id=69748.

[517] Zaza, S., Sleet, D. A., Thompson, R. S., Sosin, D. M., & Bolen, J. C. (2001). Task force on community preventive services. Reviews of evidence regarding interventions to increase use of child safety seats. *American Journal of Preventive Medicine, 21*(4 Suppl.), 31–47.

[518] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (n.d.). Available from http://www.cdc.gov/ncipc/duip/duip.htm#mv.

[519] Ibid.

[520] Shults, R. A., Elder, R. W., Sleet, D. A., Nichols J. L., Alao, M. O., Carande-Kulis, V. G., et al. (2001). Task force on community preventive services. Reviews of evidence regarding interventions to reduce alcohol-impaired driving. *American Journal of Preventive Medicine, 21*(4S), 66–88.

[521] Ahrens, M. (2000). *U.S. experience with smoke alarms and other fire alarms.* Quincy, MA: National Fire Prevention Association.

[522] The Injury Free Coalition for Kids; http://www.injuryfree.org/

[523] Ibid.

[524] National Center for Chronic Disease Prevention and Health Promotion, Youth Risk Behavior Surveillance System; http://apps.nccd.cdc.gov/YRBSS/

[525] Hatziandreu, E. J., Sacks, J. J., Brown, R., Taylor, W. R., Rosenberg, M. L., & Graham, J. D. (1995). The cost effectiveness of three programs to increase use of bicycle helmets among children. *Public Health Reports, 110,* 251–259.

[526] J. R. DiFranza and R. A. Lew.

[527] U.S. Environmental Protection Agency, Office of Research and Development, Office of Air and Radiation. (1993, January). *Fact sheet: Respiratory health effects of passive smoking: Lung cancer and other disorders.* Available from http://www.epa.gov/iaq/pubs/etsfs.html.

[328] Olson, E., & Cameron, D. (1995, February). The dirty little secret about our drinking water. New York: Natural Resources Defense Council.

[329] Plunkett, L. et al. (1992). *Differences between adults and children affecting exposure assessment, Similarities and differences between children and adults: Implications for risk assessment.* International Life Sciences Institute.

[330] Learning Disability Association of America: http://www.ldanatl.org

[331] Ibid.

[332] U.S. Environmental Protection Agency, Office of Research and Development, Office of Air and Radiation. (1993, January). *Fact sheet: Respiratory health effects of passive smoking: Lung cancer and other disorders.* Available from http://www.epa.gov/iaq/pubs/etsfs.html.

[333] National Lead Information Clearinghouse http://www.nsc.org/ehc/lead.htm

[334] U.S. Environmental Protection Agency, Office of Research and Development, Office of Air and Radiation. (1993, January). *Fact sheet: Respiratory health effects of passive smoking: Lung cancer and other disorders.* Available from http://www.epa.gov/iaq/pubs/etsfs.html.

[335] Aligne, C. A. & Stoddard, J. J. (1997). An economic evaluation of the medical effects of parental smoking. *Archives of Pediatrics and Adolescent Medicine, 161,* 648–653.

[336] DiFranza, J. R. & Lew, R. A. (1995). Effect of maternal cigarette smoking on pregnancy complications and sudden infant death syndrome. *Journal of Family Practice 40,* 385–394.

[337] Olson & Cameron. (1995), op. cit.

[338] Calderon, R., et al. (1993). Health risks from contaminated water: Do class and race matter? *Toxicology and Industrial Health, 9,* 879–900.

[339] Ibid.

[340] Ibid.

[341] Groves, B. M. (2002). *Children who see too much: Lessons from the child witness to violence project.* Boston: Beacon Press.

[342] Widom, C. S. (2000). Understanding the consequences of child victimization. In R. M. Reece (Ed.), *Treatment of child abuse: Common ground for mental health, medical, and legal practitioners.* Baltimore: Johns Hopkins University Press.

[343] Henry, D. (1999). Resilience in maltreated children. *Child Welfare, 78,* 519–540.

[344] Kirby, L. D., & Fraser, M. W. (1997). Risk and resilience in childhood. In M. W. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective.* Washington, DC: NASW Press.

[345] Ibid.

[346] U.S. Department of Health and Human Services, Administration for Children and Families. (2001). *Child welfare outcomes 1999, Annual Report.* Washington, DC: Author.

[347] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2002), op. cit.

[348] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2001). *Child maltreatment 1999.* Washington, DC: U.S. Government Printing Office.

[349] Scott, K. L. & Wolfe, D. A. (2000). What works in the treatment of batterers. In M. P. Kluger, G. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 105–111). Washington, DC: Child Welfare League of America.

[350] Teague, J. L., Thorne, J., Luckey, H. B., & Hoerger, T. J. (1998, September). *Social costs of faltering child development* (RTI Project 6030-6 FR). Research Triangle Park, NC: Research Triangle Institute.

[351] National Center for Children Exposed to Violence. See http://www.nccev.org.

[352] Saunders, B. E., Berliner, L., & Hanson, R. F. (2001). *Guidelines for the psychosocial treatment of intrafamilial child physical and sexual abuse.* Charleston, SC: Author.

[353] U.S. Department of Justice. (2001). *First response to victims of crime 2001.* Washington, DC: Office for Victims of Crime, Office of Justice Programs.

[354] National Organization for Victim Assistance. (1992). *Community crisis response team training manual.* Washington, DC: NOVA.

[355] Ibid.

[356] Ibid.

[357] CWLA, 1999.

[358] Thomlison, B. (1997). Risk and protective factors in child maltreatment. In M. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective*. Washington, DC: NASW Press.

[359] Hochstedt, N. J., & Harwicke, N. J. (1985). How effective is the multidisciplinary approach? A follow up study. *Child Abuse & Neglect, 9*, 365–372.

[360] Connolly, M., & McKenzie, M. (1999). *Effective participatory practice: Family group conferencing in child protection*. New York: Aldine De Gruyter; Pennell, J., & Burford, G. (2000). Family group decision-making: Protecting children and women. *Child Welfare, 79*, 131–149.

[361] Rycus, J. S., & Hughes, R. C. (1998). *Field guide to child welfare: Placement and permanence*. Washington, DC: CWLA Press.

[362] Ibid.

[363] Available at http://www.aecf.org/initiatives/familytofamily/

[364] Casey Family Programs. National Resource Center for Resource Family Support. www.casey.org/cnc/

[365] National Coalition Against Domestic Violence. www.ncadv.org

[366] Saathoff, A. J., & Stoffel, E. A. (1999). Community-based domestic violence services. *Future of Children, 9*(3).

[367] Martin, T. (1997) *Family violence in America: Breaking the cycle for children who witness violence. Recommendations from the 1997 Summit*. Alexandria, VA: International Association of Chiefs of Police.

[368] Ibid.

[369] Ibid.

[370] Maluccio, A., Ainsworth, F., & Thoburn, J. (2000). *Child welfare outcome research in the United States, the United Kingdom, and Australia*. Washington, DC: CWLA Press.

[371] Abt Associates. (1994, August). *Conditions of confinement: Juvenile detention and correctional facilities*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[372] Waldfogel, J. (1998). *The future of child protection: How to break the cycle of abuse and neglect*. Cambridge, MA: Harvard University Press.

[373] Berliner, L., & Kolko, D. (2000). What works in treatment services for abused children. In M. P. Kluger, G. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 97–104). Washington, DC: CWLA Press.

[374] Child Welfare League of America. (2001). *Alcohol, other drugs, and child welfare*. Washington, DC: CWLA Press.

[375] Center for Substance Abuse Treatment. (2000). *Substance abuse treatment for persons with child abuse and neglect issues: Treatment Improvement Protocol (TIP) Series #36*. Washington, DC: Substance Abuse and Mental Health Services Administration.

[376] Crowe, A. H. (1998). *Drug identification and testing in the juvenile justice system*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention; Mears, D.P. (2001, August). Critical challenges in addressing the mental health challenges of juvenile offenders. *Juvenile Policy Journal, 1*(1).

[377] Coalition for Juvenile Justice. (2000). *Handle with care: Serving the mental health needs of young offenders*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[378] Cullen, F. T., & Gendreau, P. (2000). Assessing correctional rehabilitation: Policy, practice, and prospects. *Criminal Justice, 3*, 109–175.

[379] Claassen, R. (1996). *"Restorative justice" primary focus on people, not procedures*. Fresno, CA: Fresno Pacific University. Available from http://www.fresno.edu/pacs/rjp/whatis.shtml

[380] National Institute of Justice's Restorative Justice On-Line Notebook. Available from http://www.ojp.usdoj.gov/nij/rest-just.

[381] Ibid.

[382] Ibid.

[383] Center for Mental Health Services, Center for Effective Collaboration and Practice. (1998) *Promising practices in wraparound for children with serious emotional disturbance and their families*. Available from http://cecp.air.org/promisingpractices/1998monographs/vol4.pdf.

[584] *Mental health: A Report of the Surgeon General.* (2000). Available from http://www.mentalhealth.org/features/surgeongeneralreport.

[585] Ibid.

[586] Kamradt, B. (2000). Wraparound Milwaukee: Aiding youth with mental health needs. *Juvenile Justice, 7,* 14–23; Clark, H. B., & Clarke, R. T. (1996). Research on the wraparound process and individualized services for children with multi-system needs. *Journal of Child and Family Studies, 5,* 1–5.

[587] Kamradt, B. (2000). Wraparound Milwaukee: Aiding youth with mental health needs. *Juvenile Justice, 7,* 14–23.

[588] Ibid.

[589] Foster Family Based Treatment Association website: http://www.ffta.org/.

[590] Clark, H., Boyd, L., Redditt, C., Foster-Johnson, L., Hardy, D., Kuhns, J., et al. (1993). An individualized system of care for foster children with behavioral and emotional disturbances: Preliminary findings. As cited in Chamberlain, P. (2000). What works in treatment foster care. In M. P. Kluger, G. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 157–162). Washington, DC: CWLA Press.

[591] Chamberlain, P., & Reid, J. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders; and Hawkins, R., Almeida, C., & Samet, M. (1989). Comparative evaluation of foster family based treatment and five other placement choices: A preliminary report. As cited in Chamberlain, P. (2000). What works in treatment foster care. In M. P. Kluger, G. Alexander, & P. A. Curtis (Eds.), *What works in child welfare* (pp. 157–162). Washington, DC: CWLA Press.

[592] Ibid.

[593] Cahn, E. S. (1996). Rebuilding community: The co-production imperative. In *Wise counsel: Redefining the role of consumers, professionals and community workers in the helping process.* Des Moines, IA: National Center for Service Integration, Child and Family Policy Center.

[594] Macy, J. (1998). *Coming back to life: Practices to reconnect our lives, our world* (p. 55). Gabriola Island, Canada: New Society.

[595] Bruner, C., & Chavez, M. (1996). *Getting to the grassroots: Neighborhood organizing and mobilization* (p. 7). Des Moines, IA: National Center for Service Integration.

[596] Gardner, J. (1991, September). Building community. *Independent Sector,* p. 9.

[597] Together We Can. (1997). *A guide to crafting a profamily system of education and human services* (p. 1). Available from http://eric-web.tc.columbia.edu/families/TWC/part1_3.html.

[598] Laidlaw Foundation. (2002). *Perspective on social inclusion.* Toronto, Canada: Author.

[599] Ibid.

[600] *Introduction.* (1996). In *Wise counsel: Redefining the role of consumers, professionals and community workers in the helping process* (p. 1). Des Moines, IA: National Center for Service Integration, Child and Family Policy Center.

[601] Trevino, Y. (1996). Unleashing human capital (If you care for me, don't empower me and get out of the way. In *Wise counsel: Redefining the role of consumers, professionals and community workers in the helping process* (p. 77). Des Moines, IA: National Center for Service Integration, Child and Family Policy Center.

[602] Ibid.

[603] Kinney, J., & Trent, M. Walking our talk in the neighborhoods: Building professional/natural helper partnerships. In *Wise counsel: Redefining the role of consumers, professionals and community workers in the helping process* (pp. 47–48). Des Moines, IA: National Center for Service Integration, Child and Family Policy Center.

[604] Trevino, op. cit., p. 82.

The Child Welfare League of America (CWLA) is committed to engaging people everywhere in promoting the well-being of children, youth, and families. The extent to which all of America's children are healthy, safe, and thriving will depend, in large part, on actions taken in local communities.

CWLA's *Making Children a National Priority: A Framework for Community Action* lays out a comprehensive, community-based framework to support individuals, agencies, and communities in their efforts to improve the well-being of all children and youth. The Framework Monograph features five needs that all children possess, discusses why having each of those needs met is crucial to a child's well-being, and describes promising strategies identified by researchers and others to meet those needs. The Monograph provides a framework for community action. Its companion piece, the Framework's *Community Implementation Guide*, provides practical guidance and tools for communities as they work to make children a priority.

91

CHILD WELFARE LEAGUE OF AMERICA
Headquarters
440 First Street NW, Third Floor
Washington, DC 20001-2085
202/638-2952 • Fax 202/638-4004 • www.cwla.org

ISBN 0-87868-882-2
9 780878 688869

EXECUTIVE SUMMARY

MAKING CHILDREN A NATIONAL PRIORITY

A Framework for Community Action

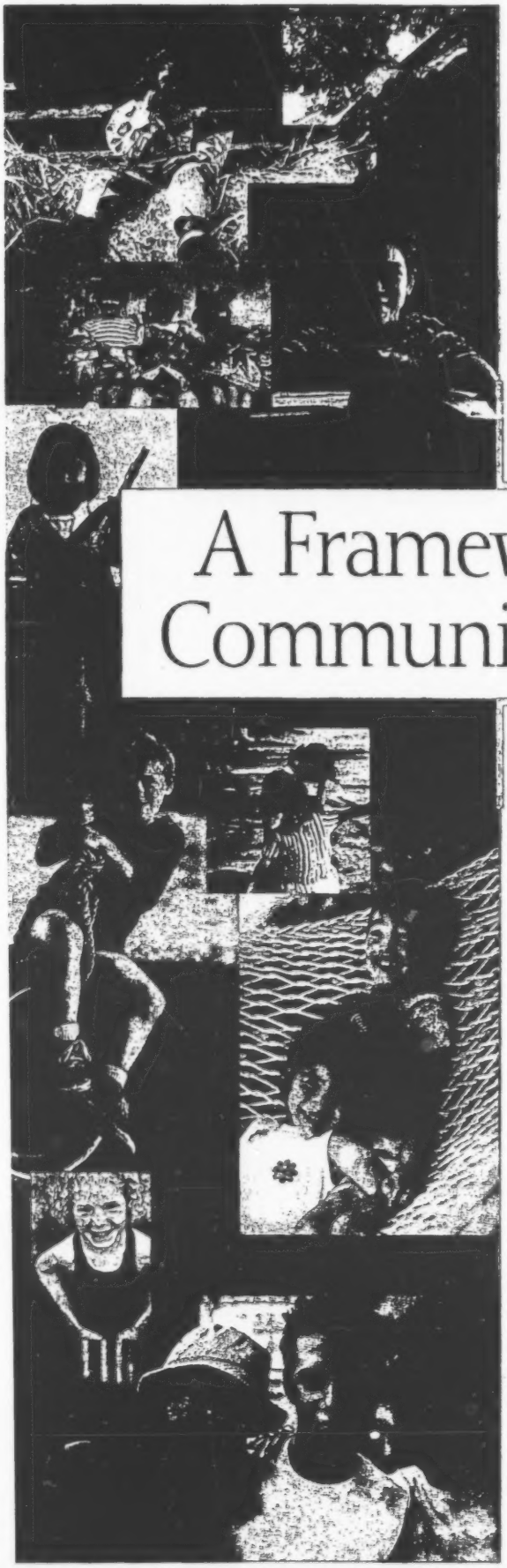
CHILD WELFARE LEAGUE OF AMERICA

PS 031367

92

BEST COPY AVAILABLE

EXECUTIVE SUMMARY



MAKING CHILDREN A NATIONAL PRIORITY

A Framework for Community Action

CHILD WELFARE LEAGUE OF AMERICA

by
Linda Jewell Morgan,
Linda S. Spears,
and Caren Kaplan

93 WASHINGTON, DC

BEST COPY AVAILABLE

The Child Welfare League of America is the nation's oldest and largest membership-based child welfare organization. We are committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.

© 2003 by the Child Welfare League of America, Inc. All rights reserved. Neither this book nor any part may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, microfilming, and recording, or by any information storage and retrieval system, without permission in writing from the publisher. For information on this or other CWLA publications, contact the CWLA Publications Department at the address below.

CHILD WELFARE LEAGUE OF AMERICA, INC.
HEADQUARTERS
440 First Street, NW, Third Floor, Washington, DC 20001-2085
E-mail: books@cwla.org

CURRENT PRINTING (last digit)
10 9 8 7 6 5 4 3 2 1

Cover and text design by Jennifer R. Geanakos

Printed in the United States of America

ISBN # 0-87868-887-0

94

BEST COPY AVAILABLE

Dear Colleagues,

Throughout our nation's history, we have made dramatic and lasting improvements in the lives of children and youth. Many children continue to be left behind, however, because their families lack resources, information, support, or opportunities to benefit fully from our nation's progress. We can do more to ensure that all children and youth in America are provided with the resources they need to grow into healthy, contributing members of society.

In *Making Children a National Priority: A Framework for Community Action*, the Child Welfare League of America (CWLA) lays out a comprehensive, community-based framework for ensuring that all of America's children are safe, healthy, and thriving. With input from its members, CWLA developed the Framework by synthesizing research findings, the practice wisdom of social service practitioners, and the experience of families and children. Its key elements are presented in the Framework Monograph and are summarized in this Executive Summary.

The heart of the Framework is a set of five universal needs of children that are closely interrelated. The Monograph discusses what we know about the importance of meeting each of these five universal needs and the extent to which we, as a nation, are currently meeting these needs for *all* children. It describes what we know about the practices and programs that can effectively meet children's universal needs and showcases examples of promising community-based efforts drawn from around the nation.

Using the Framework to organize and guide our work, CWLA will continue its efforts to make children a national priority. In partnership with our members, their communities, and other national organizations, we will refocus our powerful and diverse resources on achieving the five universal needs for all children in America. The Framework will guide CWLA in reshaping our ad-

BEST COPY AVAILABLE

vocacy efforts at the national and state levels and will help ensure that our publications, standards, research, training, and consultation efforts are accessible and relevant to those engaged in building communities and strengthening families.

We invite you to join with us in ensuring the healthy growth and safety of all children and youth in America. Please use our resources as you work to increase your community's capacity to support families and nurture children and youth, and help us inspire others by sharing your successes.

–Shay Bilchik, President and CEO
Child Welfare League of America

BEST COPY AVAILABLE

Imagine an America...

Imagine an America where *every* child is healthy and safe and where *all* children develop to their potential. Imagine that all children are nurtured, each getting what they need, as they require. Imagine that every child grows into an adult who is able to make positive contributions to family, community, and the nation.

Americans have the spirit, creativity, and perseverance necessary to make dreams come true for our children. In just the past decade, the combined efforts of millions of individuals have markedly improved the well-being of children in America. More children are benefiting from early childhood education and more youth are graduating from high school than ever before. Childhood poverty is at its lowest level in 20 years, and infant mortality has dropped significantly for all racial and ethnic groups, though substantial racial and ethnic disparities remain. Fewer youth are dying of gunshot wounds, and adolescents are committing fewer homicides. This is the right direction, but we must do more—not just in certain years or with certain children, but for all times and with every child.

We can raise the standard of living for the one in six children in America who lives in poverty.[1] We can provide secure shelter for the 1.35 million children who are homeless at some time during each year. We can prevent the deaths of 1,200 children each year at the hands of their parents or others entrusted with their care. None of our children should be placed at risk by substance abuse or by violence in our streets, in our schools, in our homes, or in our media. Equal opportunity and social justice must be made available to all children, youth, and families, particularly children of color and recent immigrants, if we are to fulfill our promise as a country.

Now is the time for us to take on these challenges. We stand at the threshold of a new era full of promise for ensuring the

BEST COPY AVAILABLE

health and safety of all of America's children. There is a wealth of knowledge at our disposal. Solutions abound! Every day, as our colleges and universities expand cross-discipline study and research, our knowledge of what is needed for the optimal development of children increases. We now know how important prenatal and early years are to the development of the brain, and we are learning more about how young people continue to grow and learn throughout their lives, shaped both by positive experiences and by trauma. We must use that knowledge.

To make substantial gains, we will certainly need to invest more in caring for our children. The human and economic costs of not investing in children are far greater than the costs of preventing problems and effectively intervening when they do occur. Each year, governments and the private sector spend billions of dollars to cope with the many negative effects of problems such as child abuse, juvenile crime, teen pregnancy, and school failure–all problems that can be avoided by investing early in the healthy development of children.

Polls indicate that the public is willing to pay more in taxes for effective services and programs.[2] We must combine this willingness to invest with the American "can do" attitude and with a commitment to implementing practices and programs that work. Together, we can make children a national priority.

MAKING CHILDREN A NATIONAL PRIORITY: A FRAMEWORK FOR COMMUNITY ACTION

Drawing on knowledge from basic and applied research, the work of its members and other social service practitioners, and the experience of families and children, the Child Welfare League of America (CWLA) has developed a *Framework for Community Action* to organize its work and to focus and support the work of communities, including parents, policymakers, practitioners, and others.

The Framework Monograph presents the key components of the Framework, including its guiding principles, the roles that key groups of people can play, and a set of five universal needs of children that once met, will result in safety, health, and optimal development.

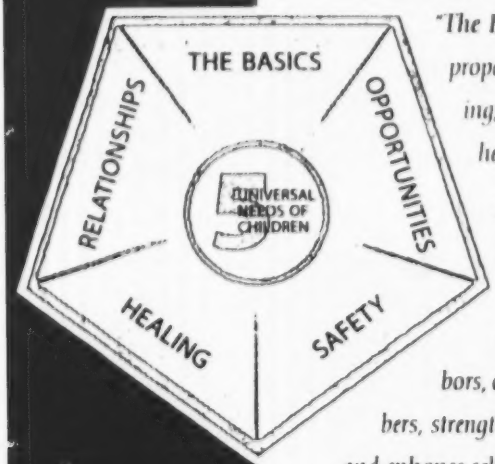
BEST COPY AVAILABLE

The Monograph discusses the importance of meeting each of the five universal needs of children, and how well America, as a nation, is currently meeting these needs for all children. It describes what is known about what works to effectively meet children's universal needs. These strategies reach across the spectrum from primary prevention and support for all children and youth to mandated interventions for those who are being harmed. They range from small actions that parents can take to formal programs undertaken by agencies and communities. The Monograph also provides key indicators to measure progress and success, along with examples of promising community efforts drawn from around the nation.

This Executive Summary contains the key components of the Framework and presents material on the issue of homeless children, as an example of what information is available in the Monograph. It also briefly describes CWLA and the resources it and its members have to offer. The Executive Summary ends with information on how to obtain copies of the Monograph and of the companion *Community Implementation Guide*, the first in a series of publications that will provide practical information, tools, and techniques that support community implementation.

THE FIVE UNIVERSAL NEEDS OF CHILDREN

At the heart of the Framework is a set of five universal needs that are closely interrelated and that must be met for our children to be safe, healthy, and thriving. They include:



***"The Basics"**: At the most fundamental level, children require proper nutrition, economic security, adequate shelter and clothing, education, and primary and preventive health and mental health care.*

***Relationships**: Close, nurturing relationships with parents, kin, and other caregivers allow and encourage children and young people to grow and thrive. Caring relationships with community members, including neighbors, coaches, teachers, and faith community leaders and members, strengthen social and relationship skills, improve self-mastery, and enhance self-esteem. Good relationships among children and youth*

BEST COPY AVAILABLE

themselves reinforce healthy behaviors and increase positive learning opportunities.

***Opportunities**: Providing a childhood full of experiences and opportunities that motivate and equip children to succeed is the collective responsibility of individuals, families, neighborhoods, and communities. Children and youth need opportunities to develop their talents and skills, contribute to their families and communities, and make positive connections to their cultures, traditions, and spiritual resources. For children with early indications of physical, cognitive, or emotional disabilities, we must provide early assessment and intervention, to prevent later, more serious problems that can unnecessarily limit their long-range potentials.*

***Safety**: Keeping children safe from abuse and neglect by their caregivers, as well as from witnessing or being victimized by family, school, or community violence, makes it much less likely that they will become either victims or perpetrators of such violence in the future. By also protecting children from the harms of discrimination, media violence, Internet victimization, environmental toxins, and accidental injury, we increase their likelihood for success.*

***Healing**: When we are unable to protect children, we must do all that we can to ease the effects of the harm they have suffered. Helping children heal involves ensuring their immediate and ongoing safety; supplying immedi-*

THE FIVE UNIVERSAL NEEDS OF CHILDREN

"The Basics"	Relationships	Opportunities	Safety	Healing
Meet Basic Needs	*Ensure Nurturing Relationships*	*Provide Opportunities for Optimal Development*	*Protect from Harm*	*Ease the Impact of Harm*
• Equality	• Nurturing relationships with:	• Opportunities for:	• Protection from:	• Protection, care, and support in response to trauma
• Economic security and stability	– Parents,	– Early childhood development	– Family violence	• Ongoing protection, care, and support
• Proper nutrition	– Kin,	– Development of school-age children	– School and community violence	
• Adequate housing	– Other adults and children	– Positive youth development	– Media violence and Internet victimization	
• A healthy start Health and health care coverage			– Discrimination	
• Education			– Accidental injury and death	
			– Environmental toxins	

BEST COPY AVAILABLE

GUIDING PRINCIPLES

Nine core principles guide the framework for community action:

Supporting families: Children grow best in families. By supporting families in nurturing their children, professionals and community members can help ensure that parents, other relatives, and caregivers have the skills and resources to raise healthy, well-adapted children.

Promoting prevention: Providing help to children and families to prevent problems before they occur is a sound social and fiscal policy. Programs and practices that nurture and protect children in their earliest development, prevent abuse and neglect, and detect and intervene at the earliest possible indication of risk should be available to all families.

Advancing social justice: Every child, regardless of gender, ability, economic status, or ethnic, racial, spiritual, or cultural background, has an equal right to have their universal needs met. All community partners can advocate for the ideals and values of social justice both locally and globally.

Working collaboratively: When people come together, collective capacities emerge that individual partners do not possess. Communities can harness this combined power to solve shared problems and work toward the common good.

Respecting and valuing diversity: Diverse cultures, traditions, and perspectives are sources of strength and creativity that community partners can draw on to nurture healthy families and children.

Building capacity: By recognizing and nurturing the assets and strengths of children, youth, families, and communities, we tap into sources of energy and creativity that have the greatest potential for meeting children's needs and encouraging their optimal growth. Consciously developing individual, group, and community capacity strengthens everyone.

Nurturing leadership: Leadership requires dedication, passion, and a willingness to take risks. It cannot be conferred simply by election or appointment to a position of authority, but rather comes from those willing and able to inspire and guide others to get things done in behalf of families and children.

Using evidence-based strategies: Applying knowledge of factors and strategies that contribute to or impede healthy human development can help community partners design and implement policies, practices, and programs that are effective in helping children thrive.

Measuring results: Using clear outcomes measures to guide and evaluate our efforts increases the likelihood that our work will result in positive results for children, youth, and families.

ate and continuing emotional support; assessing the need for and providing medical, mental health, and other needed services; and in some case, making amends through restorative justice practices.

These five needs are closely interrelated and must be met for our children to be safe, healthy, and thriving. Each need is common to every child and youth, whether they live at home, in a juvenile detention facility, or on the streets.

PRINCIPLES, PEOPLE, AND PARTNERSHIPS

Community efforts in behalf of families and children have often been fragmented, uncoordinated, and not sustainable. It is increasingly clear that helping children grow into healthy and resilient adults requires that comprehensive, collaborative, coordinated approaches be implemented by partnerships of citizens, parents, professionals, and policymakers. Giving all of America's children the opportunity to grow up healthy and strong will take the talent, hard work, and long-term commitment of individuals and groups from all walks of life.

CWLA's *Framework* suggests guiding principles to inform actions we take to ensure that the five universal needs are met for every child

BEST COPY AVAILABLE

in every community. The *Framework* also suggests the roles that key groups of people can play as we work together to ensure bright futures for all of our children.

A SELECTION FROM THE FRAMEWORK MONOGRAPH

The following discussion on homeless children is summarized from the Monograph chapter on meeting the basic needs of children. It serves as an example of the information that the monograph contains for each subissue under each of the five universal needs.

"The Basics": Housing

The goal: Adequate and stable housing.

The challenge: Although no regularly collected data exist on the number of homeless children in America, it is estimated that at least 1.35 million children are homeless during a year's time[3] and that more than 40% (540,000) of homeless children are younger than 5 years old.[4] A 1998 survey of 30 U.S. cities found that one-third of requests for shelter by homeless families were denied due to lack of resources.[5]

The causes: Poverty and lack of affordable housing are the principal causes of homelessness among families with children.[6]

PEOPLE AND PARTNERSHIPS

People are at the heart of our ability to ensure safety and well-being for all children. Working individually and collectively, these five groups of people can ensure futures filled with positive potential for all children:

Parents, caregivers, and families: Healthy families and supportive parents are crucial to children's well-being, shaping their values and behaviors in enduring ways. Communities must encourage and support caregivers in meeting the needs of their children and youth. Communities also benefit from parents' participation in and leadership of community initiatives dedicated to raising healthy, thriving children.

Children and youth: Recognizing that children are resilient, with many assets and strengths, community partners can work with them to nurture their talents and provide them with opportunities to serve and transform their communities.

Neighbors and community members: All adults must share responsibility for nurturing and supporting children and families in their communities. As coaches, mentors, neighbors, employers, and members of faith communities, people can help ensure children's healthy development and safety. By working together as members and leaders of community-based collaboratives, community residents can support comprehensive strategies that will strengthen families and help all children reach their full potential.

People working in service agencies, institutions, or systems: Professionals, natural helpers, and volunteers who work for public service agencies have specialized skills and talents essential to the success of community partnerships' work in behalf of children and youth. They can also act as conveners, catalysts, and facilitators for a wide range of community change efforts.

People who influence laws, traditions, culture, and society: Elected officials and other policymakers, business executives, and spiritual, social, and scientific leaders all exert considerable influence on ways our communities shape and support the growth of children and youth. These individuals can ensure the safety and well-being of children by supporting community-based initiatives that encourage local creativity and accountability.

BEST COPY AVAILABLE 102

The consequences: Homeless children suffer from more health problems and use emergency services to a greater extent than housed children.[7] Homeless children also have higher blood lead levels, higher inpatient pediatric admission rates, delayed immunizations, poorer nutritional status and heightened family food insecurity, greater developmental delays, and lower school attendance rates.[8]

The solutions: Many strategies involving many people and systems address the problem of homeless children and families. More resources and better coordination of existing resources are both needed. It costs more to maintain families in homeless shelters than to help them stay housed, so prevention is the key. (Note: The issue of economic security for families is addressed earlier in the chapter.)

Preventing homelessness among families with children: Homelessness prevention programs provide legal assistance to tenants faced with or involved in eviction procedures and provide financial assistance to enable tenants to pay back rent.[9] Other services include case management, volunteer assistance, landlord/tenant mediation, and, if housing is lost, assistance with rehousing without requiring a homeless shelter stay.[10]

Shelter and homeless services provide different levels of services and shelter for homeless and precariously housed families–prevention, emergency shelter, transitional housing, and permanent supportive housing (service-enriched housing). Children and youth residing in homeless shelters need to have easy access to quality early intervention programs, education, and quality medical care.

Providing affordable rental housing for low-income families: The Housing Choice Voucher Program (formerly Section 8) is the primary federal program assisting very low-income families to afford adequate housing in the private market. Local housing programs can assist poor families in gaining economic security and stability through the provision of and linkage to supports and services, such as education, training, health care, counseling, and child care.[11]

BEST COPY AVAILABLE

The Family Unification Program (FUP) provides rental subsidies to families with children who have been placed or who are at risk of placement in foster care primarily because the family lacks adequate housing. FUP enables families to move into more adequate housing by subsidizing their rent through the Housing Choice Voucher Program.

Minnesota's Family Homeless Prevention and Assistance Program addresses homelessness by providing state funds used by counties and community nonprofit organizations, including Temporary Assistance for Needy Families block grant dollars, to help families remain in their homes, to rehouse those who become homeless, and to shorten the length of time families spend in shelters.

Expanding home ownership for low-income families: Programs that assist low-income families in purchasing and maintaining homes provide pre- and postpurchase financial assistance and offer counseling and training in home maintenance and foreclosure prevention.[12] Such programs show low default rates[13] and require multiple funding sources, deep subsidies, and long-term partnerships among community groups, financial institutions, foundations, government agencies, and private nonprofit organizations.[14]

Since 1976, Habitat for Humanity has built more than 120,000 homes worldwide, including more than 36,000 homes in the United States. The program uses "sweat equity," motivated volunteers, and a revolving loan fund capitalized with grants and contributions.

In local efforts, such as the Salisbury Neighborhood Housing Services in Salisbury, Maryland, high school students build homes for low-income families.

Co-housing is an emerging trend that has the potential to expand home ownership among low-income families. It provides the privacy of an individual household, along with shared facilities, such as community dining rooms, children's playrooms, workshops, guest rooms, and laundry facilities, which provides opportunities for shared child care, social contact, and economic efficiency.[15]

BEST COPY AVAILABLE

CWLA'S COMMITMENT

CWLA stands ready to assist communities in their new and existing efforts to improve children's safety and well-being. Established in 1920, CWLA is an association of more than 1,100 public and private nonprofit agencies committed to a clear vision:

> *A future in which families, neighborhoods, communities, organizations, and governments ensure that all children are provided with the resources they need to grow into contributing members of society.*

The Framework organizes and guides CWLA's continuing efforts to make children a national priority. Its clear vision, common language, and universal needs structure will focus our work. Through its programs, publications, research, conferences, professional development, and consultation efforts, CWLA will provide resources and services to assist individuals, agencies, and communities to strengthen the knowledge, skills, and resources they need to meet the universal needs of children. The strengths and expertise of CWLA's member agencies will continue to enrich our work as well as that of local communities as groups pursue this vision.

The Framework *Community Implementation Guide* is the first in a series of guides that will provide information on approaches, practical tools, methods, and resources for initiating and sustaining community change.

Through its Research to Practice (R2P) initiative, CWLA explores, analyzes, and disseminates information on effective practices and programs that help communities meet the needs of children and families. CWLA speaks with authority and candor about the status and needs of American children, youth, and families, providing a strong voice for its members and the families, children, and communities they serve.

By creating a framework and offering tools and resources that communities can use to support families and children, CWLA hopes to help ensure that every child in America has the opportunity to reach his or her full potential. CWLA remains committed to serving as a strong voice for America's children and will direct its energy and resources to work in partnership with parents, communities, and professionals to assure a bright future for every child. Please join us.

BEST COPY AVAILABLE

CONTACT INFORMATION

To order the Framework Monograph (stock #8822) or the *Community Implementation Guide* (stock #8889), please visit the CWLA website: www.cwla.org/pubs, e-mail: cwla@pmds.com, or call 800/407-6273. For information about the Framework, please write to us at theframework@cwla.org.

BEST COPY AVAILABLE

Endnotes

[1] Statistic from the year 2000.

[2] Findings from a 1999 survey regarding child abuse, for example, indicated that Americans think that it is a serious problem, that everyone shares responsibility for solving the problem, and that they would be willing to pay increased taxes to address it.

[3] Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). *Homelessness: Programs and the people they serve: Summary report–Findings of the National Survey of Homeless Assistance Providers and Clients.* Washington, DC: Urban Institute. Available from http://www.urban.org/housing/homeless/homeless/html

[4] Ibid.

[5] U.S. Conference of Mayors. (2000). *A status report on hunger and homelessness in America's cities.* Washington, DC: Author.

[6] National Coalition for the Homeless. (1999, June). *Homeless families with children: NCH Fact Sheet #7.* Washington, DC: Author.

[7] Weinreb, L., Goldberg, R., Bassuk, E., & Perloff, J.N. (1998, September). Determinants of health and service use patterns in homeless and low-income housed children. *Pediatrics, 102*(3), 554–562.

[8] Sherman, P., & Redlener, I. (1999). Homeless women and their children. In H. M. Wallace (Ed.), *Health and welfare for families in the 21st century.* Sudbury, MA: Jones and Bartlett.

[9] Pew Partnership. *Thriving neighborhoods. Affordable housing.* Available from http://www.pew-partnership.org.

[10] Lindblom, E. N. (1991). Toward a comprehensive homelessness-prevention strategy. *Housing Policy Debate, 2*(3), 957–1094.

[11] Pew Partnership, op. cit.

[12] Neighborhood Reinvestment Corporation. (1996). *Winning strategies: Best practices in the work of home ownership production.* Washington, DC: Author.

[13] Applied Real Estate Analysis, Inc. (1998). *Making home ownership a reality: Survey of Habitat for Humanity (HFHI), Inc. homeowners and affiliates.* Washington, DC: U.S. Department of Housing and Urban Development.

[14] Rohe, W. M., Quercia, R. G., Levy, D. K., & Biswas, P. (1998). *Sustainable nonprofit housing development: An analysis of the Maxwell Award Winners.* Washington, DC: Fannie Mae Foundation.

[15] McCamant, K. M. *Cohousing communities: A model for reinvigorating urban neighborhoods.* Available from http://www.newvillage.net/1urbaninfill.html.

BEST COPY AVAILABLE

The Child Welfare League of America (CWLA) is committed to engaging people everywhere in promoting the well-being of children, youth, and families. The extent to which all of America's children are healthy, safe, and thriving will depend, in large part, on actions taken in local communities.

CWLA's *Making Children a National Priority: A Framework for Community Action* lays out a comprehensive, community-based framework to support individuals, agencies, and communities in their efforts to improve the well-being of all children and youth. This Executive Summary highlights the Framework Monograph's discussion of the five needs that all children possess, discusses why having each of those needs met is crucial to a child's well-being, and describes promising strategies identified by researchers and others to meet those needs. The Framework's companion piece, the *Community Implementation Guide*, provides practical guidance and tools for communities as they work to make children a priority.

BEST COPY AVAILABLE

CWLA 168

CHILD WELFARE LEAGUE OF AMERICA

Headquarters
440 First Street NW, Third Floor
Washington, DC 20001-2085

ISBN 0-878 68-887-0

9 780878 688876

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

[X] This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

[ ] This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").

ED 203 367